

Bulletin
of the
Massachusetts Medical Society

No. 3. November 1, 1913

MEDICAL COMMUNICATIONS

VOL. XXIV — PART II

1913
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ADDRESS OF THE CHAIRMAN OF THE SECTION OF TUBERCULOSIS.

J. F. A. ADAMS, M.D.,
OF PITTSFIELD.

DELIVERED JUNE 10, 1913.

IN opening this session of the Section of Tuberculosis, our first thought is one of profound sorrow, due to the great loss which we have sustained in the death of Dr. Arthur T. Cabot, which occurred on the fourth of last November.

For the last seven years of his life Dr. Cabot stood at the head of the movement for the suppression of tuberculosis in this society and in this state.

While President of the Massachusetts Medical Society in 1905 and 1906, he took this subject for the text of the addresses which he made to the District Societies as he visited them in rotation, being satisfied that this was the most important subject to which he could devote so exceptional an opportunity for awakening the interest of physicians throughout the state.

He originated the Tuberculosis Committees of the District Societies, organized them under the name of the Associated Committees; and it was through his influence that the Section of Tuberculosis was added to the activities of the state society.

In 1907, he became Chairman of the Board of Trustees of Hospitals for Consumptives, and thenceforward his time, his strength and his great abilities were almost wholly devoted to the anti-tuberculosis cause.

That such a man as Dr. Cabot should thus become the enthusiastic standard-bearer of this cause gave a wonderful impulse to the anti-tuberculosis campaign, an impetus which will long continue to be felt.

This campaign against tuberculosis is one of the most remarkable movements of this remarkable age. It is actually ridding the world of one of the worst, if not the very worst enemies of the human race. It has reduced the mortality rate from consumption in Massachusetts, already, to one third of what it was forty years ago, and it is gradually lifting from the earth a dark cloud by which it has long been over-shadowed.

Dr. Cabot believed that active participation in the war upon this disease had become, now that it was known to be infectious and preventable, the highest duty of the medical profession, and this belief became the controlling motive of the closing period of his life.

What can we do to honor his memory? What monument can we rear to show the love and reverence with which his great career has inspired us? Of what his own choice would be there is no doubt. He would ask us not to let the work suffer through his withdrawal, but to continue the fight with the same courage, the same devotion, the same pertinacity, and the same confidence in success which were ever conspicuous in his own labors.

This war upon consumption is everybody's business.

The contagion of disease must be opposed by a contagion of intelligence. No human being exists who cannot be of some use in passing on the message. But, before all, this is the business of the medical profession, all of whose members have the knowledge which fits them for leadership; and, having this knowledge, it is our duty to use it for the public good, even though this may not be in our special line, even though it actually takes money out of our pockets, as it certainly must. The physician who allows

commercialism to swerve him from this duty is not acting in the true spirit of our noble profession.

By the public our profession is regarded with respect and honor, and this consideration is not deserved unless we esteem it our bounden duty to sacrifice ourselves constantly for the public good. We should therefore all become missionaries, seeking opportunities to instruct and advise, aiding and abetting the efforts of city and state and striving to perfect ourselves in a knowledge of this disease, and especially in the ability to detect it in its incipient stage, a task as difficult as it is important.

The subject of state and municipal control is of such vast importance, and is still beset with so many perplexing problems that we have this year returned to this aspect of the tuberculosis question and have arranged a programme dealing with practical problems of this class, the key-note being the desire to ensure more complete coördination between the various public agencies and to help to overcome the difficulties by which they are at present seriously hampered.

ARTICLE XX.

THE IMPORTANCE OF EDUCATION IN THE
TUBERCULOSIS CAMPAIGN.

BY LYMAN ASA JONES, M.D.,
OF NORTH ADAMS.

DELIVERED JUNE 10, 1913.

THE IMPORTANCE OF EDUCATION IN THE TUBERCULOSIS CAMPAIGN.

The following quotations are taken from a Report presented to the Legislature of Massachusetts in 1850, by a Sanitary Commission, appointed under a Resolve of the preceding year.

"We believe that the conditions of perfect health, either public or personal, are seldom or never attained, though attainable;— that the average length of human life may be very much extended, and its physical power greatly augmented;— that in every year, within this Commonwealth, thousands of lives are lost which might have been saved;— that tens of thousands of cases of sickness occur, which might have been prevented;— that a vast amount of unnecessarily impaired health, and physical debility exists among those not actually confined by sickness;— that these preventable evils require an enormous expenditure and loss of money, and impose upon the people unnumbered and immeasurable calamities, pecuniary, social, physical, mental and moral, which might be avoided;— that means exist, within our reach, for their mitigation or removal; and that measures for prevention will effect infinitely more, than remedies for the care of disease."

"We recommend that the causes of consumption and the circumstances under which it occurs, be made the subject of particular observation and investigation."

Immediately following this recommendation are these statements taken from a circular issued by a Dr. Fisher of Boston, in 1840 or 1841:

"No remedial agent has ever yet been, and probably never will be, discovered, which will cure the malady

when once developed in the lungs. It becomes, therefore, the duty of those who are aware of this fact and of the mortality which consumption occasions, to ascertain the causes of the disease, and to inform the public how these causes may be avoided. If the mortality produced by this disease is ever to be lessened, it is to be effected by preventive means. These means, when known and fully appreciated by the community, will be adopted, to a greater or less extent, and by their adoption a vast amount of human suffering and human life will be saved."

It is difficult to realize that these quotations, which so accurately outline the work of preventive medicine, as it is organized today, including the campaign against tuberculosis, were written more than sixty years ago. It is even less easy to understand why the organization of this work has been so long delayed; why it is only now beginning to receive the general recognition which it deserves; why there are so many obstacles to be overcome, and why the results at times seem so meagre and unsatisfactory. This is especially true with reference to the efforts for the eradication of tuberculosis.

For our encouragement, however, attention should be called to the fact that at the time the above report was written, the death rate from tuberculosis in this state was practically 400 per 100,000 while in 1912, based on the returns of 89 per cent of the population, the death rate was only 110 per 100,000.

Of recent years the efforts for the control and prevention of tuberculosis have doubled and redoubled. The State Sanatorium at Rutland was established in 1898. The institutions at Reading, Lakeville and Westfield were authorized in 1907. Tuberculosis was made a reportable disease throughout the state in 1907. More recently laws have been passed requiring cities and towns, under certain conditions, to establish local hospitals for the care of these

cases. Likewise dispensaries are to be maintained. Many local antituberculosis societies and camps have been organized.

Repeated investigations of the problem have been made under authority of the Legislature. Each step in advance has been accompanied by the hope that now the problem would be solved. But in each instance, while progress has been made, more difficulties have arisen, or perhaps better, there have followed appreciation and recognition of additional factors concerned in the campaign, such as nutritional, and housing problems, social relations, the necessity for follow-up work in reference to arrested cases, etc., so that the whole question of eliminating tuberculosis seems to become more complex than ever.

The real explanation of this condition, and the annual suggestion of new measures, is to be found in the attitude of the medical profession and of the general public. The subject of tuberculosis is agitated by an increasing number of those who are especially interested in preventive medicine, and by others who are coming to appreciate the vast amount of suffering and economic waste involved in the continued spread of the disease.

But the general public is yet ignorant of these things, ignorant, because, save by those specially interested, it does not yet individually grasp the significance of the facts so frequently presented.

Tuberculosis in its various forms has been so constant a feature of daily life, in the home and in the community, that it is calmly accepted as a natural accompaniment of such daily life. And yet let any more acute illness occur in that same community, an acute illness involving far less of suffering and death than tuberculosis, and the people of the locality rise in indignation and fear, demanding action by its authorities, to the end that the plague may be stopped.

If this same public had a proper realization of what the constant presence of tuberculosis involved, instead of opposing so many obstacles to the carrying out of preventive measures, would it not at once furnish the means necessary, and demand and insist that present measures of known value be generally carried out?

The ignorance of the public and misconceptions regarding tuberculosis are responsible for many of the obstacles to be overcome.

The individual is often unwilling to admit that he has tuberculosis. Feeling somewhat out of health he visits a physician. Upon being told that he probably has consumption, he refuses to accept the diagnosis and seeks another physician, repeating the process until he meets a physician who through lack of ability to recognize the beginning of the disease, or through lack of proper ethical standards, tells him he is merely run down and that he needs a little rest or tonic. When the individual finally realizes that he has tuberculosis, the disease is advanced to a point where its arrest is unlikely or impossible.

Or an intelligent patient, feeling poorly, and suspicious as to his condition, goes to his physician, who assures him after a hasty examination, that there is no trouble, that he is merely tired out, and that a short rest will set him right. Reassured the patient follows instructions, soon returns to work, and when the difficulty is finally recognized, the condition is much advanced, and the time necessary for recovery — if indeed such is possible — is much prolonged.

Another physician, though he realizes that the patient has incipient tuberculosis, reasons that if he informed the patient of the disease, the patient, not wishing to know of his condition, will seek some other physician who will tell him he has no serious trouble, so lets the matter go that he may retain his patient. In this way much valuable

time is lost and the patient's chances of recovery are seriously jeopardized.

If the public and physicians could learn and appreciate the importance of an early recognition of the disease; if they could realize that a sense of fatigue out of proportion to the work done, that a loss of weight, that a slight cough continuing over a month or two, accompanied by a fractional rise of evening temperature, unless entirely and satisfactorily explained on other grounds, even if unaccompanied by physical signs, are strongly suggestive of beginning tuberculosis, and that this is the time to begin appropriate treatment, a long step in advance would be gained.

If the public could be brought to thoroughly believe that by the observance of simple precautions and care as to the disposal of sputum a person afflicted with consumption could safely work or live in their midst, much suffering and hardship could be avoided.

If the public could understand that tenements or rooms occupied by those ill with the disease should be thoroughly renovated before being occupied by others, many cases would be prevented.

If physicians were fully impressed with these things and the necessity for them, they would insist that their patients observe rules, and that the necessary precautions be taken.

Though we have numerous laws bearing on health and sanitary conditions, it is not easy to secure their enforcement until the public, the health authorities, and physicians are firmly convinced of the need for carrying them out. For such education of the public the medical profession itself is largely responsible, because physicians are in close contact with their patients, who look to them for advice and guidance.

This ignorance and the lack of appreciation on the part of the public and physicians is the underlying difficulty or obstacle in the different lines of work looking toward

the prevention of tuberculosis. Hence the chief problem in this work, which applies also to other lines of preventive medicine, is the necessity for the education of physicians, and, indirectly, largely through them, of the public.

We are all willing to spend money for those things which we regard as needful or desirable. The facts regarding tuberculosis should be made a matter of common knowledge, and should be presented in such a manner that all will come to regard them as things necessary to be done for our personal good and protection. When this is accomplished there will be no lack of funds to do with, no reluctance to provide the means for any branch of anti-tuberculosis work which is based on sound and effective lines.

Much has already been accomplished by way of spreading accurate knowledge regarding the prevention of this disease. Much more requires to be done.

When appendicitis was first receiving attention some years ago many physicians waited till abscess formation before advising operation. Now no intelligent physician pursues such a course. So with tuberculosis, all physicians, instead of those especially interested in or working with tuberculosis, must become impressed with the picture of incipient tuberculosis and make their diagnosis accordingly instead of waiting till the disease is advanced before declaring that a patient has the disease.

This applies especially to those who studied medicine before the recent widespread campaign for the prevention of tuberculosis began, ten or fifteen years ago.

This educational work must be done continuously. Spasmodic efforts will not avail. The subject must be kept continually to the fore, till the attitude is similar to that of the physicians and the public toward appendicitis at the present time. This object may be assisted in various ways.

Students in medicine should have the facts concerning the

prevalence and spread of the disease firmly impressed upon them. They should be fully familiar with the earliest symptoms of the disease. It would be of advantage if all senior students could spend a week in a sanatorium where incipient cases are cared for. They should have definite and detailed knowledge as to the treatment of such cases, and of the precautions necessary to protect other members of the household and fellow workers. They should know how to reassure those who are well, and to avoid giving needless alarm, to the end that unnecessary hardship may not be inflicted on patients.

This same knowledge should be brought home to those older in practice through frequent presentation of the subject in medical societies, and through circulars of information sent out at regular intervals, for unfortunately many who particularly require this knowledge are least often found in attendance at such meetings.

The same knowledge should be brought to the attention of the public through the systematic publication of suitable articles in the press, particularly in the smaller daily and weekly papers.

Because their work should be directed much more toward preventing disease than merely caring for sickness when once it is present, local boards of health might very properly use some of their funds in advertising, inserting in the local papers from time to time, suitable concise statements regarding tuberculosis.

One of the most practical measures for affording education and instruction concerning tuberculosis in the home, is the employment of visiting nurses by local boards of health, private organizations and anti-tuberculosis societies. Through such nurses the well members of an afflicted household may receive detailed instruction which will enable them to keep well, and the patient will learn to observe the precautions necessary to protect others, or that necessary

precautions cannot safely be relaxed simply because the patient is no longer in an institution. Physicians as a rule are unfamiliar with these small details, or do not take time to impress properly upon the patient the necessity for them.

Another agency for bringing knowledge to the general public concerning preventive medicine, including tuberculosis, is the moving pictures. This means of entertainment has grown enormously since its introduction a few years ago, and already a beginning has been made along the line of health instruction by this means. But it could be extended much more. Certain films relating to tuberculosis are now obtainable. Others could be prepared and furnished to moving-picture theatres by state or local boards of health for frequent exhibition. For the showing of these things once does not suffice. Impressions of the single exhibition are soon lost in the midst of many other impressions, hence pictures relating to health conditions must be frequently repeated.

There is also an opportunity for the presentation of correct knowledge before lodges, societies, teachers' associations, parents' associations, etc. Such opportunities could be greatly increased if local boards would provide funds to secure competent speakers.

Traveling health exhibits have been employed in the preventive medicine campaign with gratifying success in California, in Louisiana and in Maryland.

The exhibits included numerous charts illustrating the vital statistics of the state, showing the relations between health and diseases; with especial prominence given to the prevalence of tuberculosis in the state. Models were shown illustrating tenement conditions unfavorable and favorable to tuberculosis, showing how present-day methods of treatment are carried out, or how they may be adapted to modest homes. Model dairies and barns were shown. Models

were shown also illustrating the manner of typhoidal pollution of domestic and public water supplies and how such pollution can be avoided. In some instances lantern slides were prepared from pictures taken in the town where the exhibit was temporarily located showing how sanitary measures might be applied practically to that particular locality.

Such an exhibit, in charge of trained demonstrators, following a given route, well advertised, in coöperation with local boards of health, with arrangements made in advance for visits from school children and other bodies, could not fail to accomplish much good. It would seem well worth while that the state, through the State Board of Health, should undertake such an educational measure.

However valuable any specific measures for the control of tuberculosis may be, the good which may be accomplished must of necessity be greatly enhanced in proportion as the public becomes thoroughly informed as to the extent of the problem, and individually appreciative of its own responsibility in the matter.

As members of the medical profession we, who rightly should lead the way in the advance against tuberculosis, we especially, every one, should not be found lagging behind the intelligent layman in favoring measures of established and recognized value against tuberculosis, and much less should we be found expressing opposition to such measures.

ARTICLE XXI.

THE TUBERCULOSIS PROBLEM FROM THE
POINT OF VIEW OF LOCAL BOARDS
OF HEALTH.

BY BRADFORD H. PEIRCE, M.D.,
OF CAMBRIDGE.

DELIVERED JUNE 10, 1913.

THE TUBERCULOSIS PROBLEM FROM THE POINT OF VIEW OF LOCAL BOARDS OF HEALTH.

In these days when the question of tuberculosis is so much before the public, we often read of what this or that organization is doing to eradicate the disease, but we hear very little of the actions of the local authorities except perhaps to learn that they are making no effort or are absolutely to be condemned.

Before bacteria were heard of certain diseases of rapid evolution such as smallpox, scarlet fever and diphtheria were found by experience to appear in epidemics. Experience with such epidemics showed that isolation reduced the number of cases. To prepare for and carry out isolation and thus cut down the spread of contagious disease was the primary reason for establishing local boards of health.

From time to time other matters pertaining to the general health of the municipalities were given into the care of these local boards, very often as the result of some advance in medical knowledge or of public agitation.

During the last few years the people have discovered the great economic loss due to tuberculosis. A constantly increasing demand for the prevention of the spread of this disease has manifested itself, and of course the local boards of health were the logical candidates for the responsibility.

Some of these boards accepted it at once and enacted regulations requiring the reporting of every case. In the places where this requirement existed the enthusiastic physicians complied, while those not so enthusiastic regarded it as

an additional burden, even none of the board of health's business, and neglected to report their cases unless frequently prodded.

The agitation continued, and by the amendment of an existing statute (1) the State Board of Health in 1907 designated tuberculosis "a disease dangerous to the public health" and therefore reportable by law. Since that time so much legislation has been offered, part of which has been enacted, that the local board of health has had great difficulty in deciding what its policy should be. It takes time to develop a campaign such as is necessary against tuberculosis and it is distressing to expend much effort and money in one direction one year and find that the next, a great deal, if not all of the previous work has gone for nothing.

Under the law (2) some municipalities established isolation hospitals for tuberculosis, then the state established the Trustees of Hospitals for Consumptives, built three more sanatoria, and said (3) that any person whom the Trustees wanted to send to a state hospital could go and the city or town in which that person had a legal settlement must pay the bill no matter whether or not the place in which he had a settlement could provide a bed for him.

It costs four dollars a week to board a patient in a state hospital because the state shares the expense, whereas it costs from eight to fifteen dollars to board a patient in a local hospital. Is it any wonder that those places without local hospitals failed to establish them and that those places with hospitals already built objected strenuously to paying for patients sent to state hospitals against their wishes while maintaining hospitals of their own with many empty beds? Why should the judgment of local officials be handicapped more in tuberculosis than in any other disease?

We have never objected to a patient's going to any hospital he wished so long as he or his friends paid his board, but we have insisted that if we were to stand the expense we would

provide for him in our own hospital. In this we have been backed up by the Trustees in nearly every case, except in the incipient cases, although the Trustees have absolute power to deny us this right if they so desire.

Often we are called on to provide for the tubercular patient who has no legal settlement. No matter what it costs us to care for this person, the State Board of Charity will never reimburse for the full expenditure. Sometimes the State Board of Charity says it will not pay anything if the patient is able to go to Tewksbury. Should the patient refuse to go, as many do, we are compelled to discharge him or isolate him at our own expense. Furthermore the State Board of Charity does not consider itself bound by the laws governing notice and denial of liability, and in cases of doubtful settlement, delays so long before notifying the local board that it is not responsible, that there is legally no time left for the local board to serve notice on a city or town in which the patient may have a legal settlement. Cities and towns must notify the State Board of Charity of liability within five days. The State Board of Charity often takes two or three years to notify cities and towns.

The legal side of the problem is but one of the difficulties. Much more trying at times are our relations with physicians and with laymen interested in the subject.

So far as physicians are concerned we are improving. They seem, in Cambridge at least, to be less and less dependent on a positive sputum for diagnosis and more anxious to get their cases reported before the death certificates come in. Progress in this direction is slow, largely because even the best of physicians hesitate to make a definite stand without actually finding tubercle bacilli when it means so much to the patient. I believe that the men who wilfully conceal cases are few and far between, though many who fail to report, offer the excuse that someone else has been treating the case and supposedly had reported it. It is

a good idea to insist that every physician report every case as soon as he makes a diagnosis no matter what the previous history has been. More than one physician has informed me that he desired assistance on some case but dreaded to report it for fear the social workers or other misguided enthusiasts would get in on it and set everybody by the ears.

This brings us to a most perplexing phase of the situation, namely the relations between the interested laymen and the local boards of health.

Boards of health are official bodies upon whom are conferred certain legal powers oftentimes very indefinite, because the statutes conferring the powers are in several instances of origin back as far as 1792 and many times modified. It is interesting to read (4) that if a disease dangerous to the public health "exists in a town, the selectmen and board of health shall use all possible care to prevent the spread of the infection, and shall give public notice of infected places to travellers by displaying red flags at proper distances and by all other means which in their judgment may be most effectual for the common safety." This seems to make it mandatory that a red flag be placed on every house in which there is a case of tuberculosis.

By interested laymen I mean philanthropic individuals, members of societies organized to prevent the spread of tuberculosis, and social workers. They are all earnest, enthusiastic, and well meaning. It is doubtful if any two of them have the same amount of common sense or the same degree of knowledge of the disease. A few with whom I have come in contact are well posted, see our difficulties, sympathize with us and give us valuable assistance. The majority know as little about the tubercle bacillus and its lesions as we do about the organism of smallpox. They are just as apt to cross the street when they see a tuberculous person approaching as they are to go round the block rather than pass by the diphtheria hospital. There are

people who say to the local board of health, "You should do this," or "You should do that"; furthermore they do not hesitate to tell patients that the board of health is obliged to take care of them and if it does not do so it is neglecting its duty. They resent it if the board of health makes different plans from theirs for a particular patient, with the result that many patients become confused and disheartened. They advertise in large letters and red ink that "Tuberculosis Can Be Cured" but in much smaller type add the all-important statement "if taken in time." They clamor to have this or that pet scheme tried which they are sure will clear up the whole situation.

This is all very well in the place where little or nothing is being done, but where the local board of health is doing all it can, I feel most strongly that these individuals should coöperate with the board of health and not that the board of health should coöperate with them.

Another difference in point of view between the layman enthusiast and the board of health is manifest when we consider that their sole object of attack is tuberculosis, while we are fighting not only tuberculosis but scarlet fever, diphtheria and other much more rapidly spreading diseases. It may and does happen that the entire effort of the board of health must be concentrated on an epidemic of scarlet fever. Delay in scarlet fever would be disastrous but tuberculosis correspondence can wait.

A month or two ago I was informed that a lecturer was using a picture of a large apartment block in Cambridge to illustrate unsanitary living conditions and describing this particular building as a "hot bed for tuberculosis." I have heard residents of the city call it by the same name. Not aware that it was such a dangerous place, I made some inquiry.

The block faces on four streets and contains about ninety apartments some of which open only onto a shaft. Of those

apartments opening onto a shaft only one is occupied and that by a single man who is not there much of the time. The others are used for storage. There are seventy one families in the building at present, mostly of Polish or other foreign birth. The sanitary condition of the premises is certainly no worse than that of many others in the city and the owners are quite willing to keep them in as good condition as they can. During the nine and one-half years since January 1904, when tuberculosis became reportable, we have had but six cases reported from this block. Considering the locality, the class of people, their occupations, mode of life, and itinerant propensity, this is a very low ratio, lower indeed than that of other houses near by. To call this block a "hot bed for tuberculosis" is an extravagant statement, hurtful to the property, the owners, the board of health, and, to common sense people, hurtful to the cause.

Of all the non-medical workers with whom boards of health touch elbows the most frequent contact is with the social workers. Folks (5) has dealt with this subject in a very common sense way. Among other bits of good advice he remarks that points of contact between health officers and social workers should not be points of conflict. Not as yet have we attained to this in the tuberculosis problem. The fault is not entirely with the social workers but until they individually and officially "uphold, strengthen and dignify" health administrations the blame must rest largely on their shoulders.

The social workers with whom I have had dealings are inclined to regard boards of health as a means to their ends, or if, as they say, through shirking, ignorance, laxity or what not, failing to give them the assistance they demand, as bodies to be circumvented and left out of consideration altogether. They do not hesitate to criticise health officers and institutions, to drag patients from their physicians, or to tell us

what we ought to do, yet I would give them all credit for being interested, enthusiastic and conscientious.

Over and over again we learn of a case that is being treated somewhere, never reported to us, unknown to the family physician, but which has been discussed with some worker in our town. Those who are dealing with it say, "Why I supposed some one else had reported it." Often we have to ask the Trustees who it was that made out the application for a case that has been living in the city right along. I have several letters written concerning several patients in which one social worker insists that if the board of health will not consent to her plan then the board must take the responsibility. She might have added that the board of health had never asked her to assume any responsibility and we could have said that if she had not meddled with the cases they would have all been taken care of properly with far less discomfort. I have another letter from another worker in which she tells a patient's mother that she does not think our hospital "is at all a fit place." She goes on to say, "I realize that it is very hard for you to know who to believe when different societies tell you different things." The family was one that could afford to pay its physician yet she tried to get them all to the hospital she represented. Still another social worker with a very sick patient to provide for from several miles out of town begged us to take him in. We did so on her assurance that she could and would get the town in which he had a settlement to assume financial responsibility. The patient off her hands, her connection with the case apparently ceased. These same women go to public hearings and denounce physicians and boards of health.

Settlement law is a stumbling block for all of us. Nothing could be more confusing. A person interested in a particular case will argue with exasperating persistence that because the patient lived in a certain city for twenty years or more

his legal settlement must be in that place, whereas he may never have paid any taxes and have gained a settlement elsewhere through his father or mother. Such arguments lead to distrust and ill feeling.

The problem of the vicious, incorrigible consumptive is one which probably no municipality of any size has escaped. I have heard and read many discussions of the subject, mostly by those who have never been obliged to face it. None have discussed it so sensibly as Callahan (6) at the recent conference at Holyoke. No matter how clear it may appear on paper it is not so simple as it seems. To cite a case may not be amiss.

A. B. was admitted to our hospital where he remained about a month creating more or less disturbance. He left to go on a drunk. After about another month, much talk by interested citizens and a good lecture he was readmitted. This time he stayed a little over three months greatly to the disgust of many inmates who were self respecting. His conduct was such that he could not remain. We next boarded him with a person experienced in the care of consumptives. Here too, he acted so badly that the woman would not keep him. I told Dr. Hawes all about it and he consented to giving the man a trial at a State sanatorium. While waiting to enter, we even provided him with money, very unwisely, until, through the efforts of others combined with ours he was admitted to a home. He stayed in the home a short time, left, had a severe hemorrhage on the street and died in the hospital to which he was taken before he could be admitted to a State sanatorium. We had no jail in which to keep him if we had possessed unquestionable power to seize him, nor could we allow him to upset all discipline at the hospital. In spite of all we had tried to do we received a letter from an enthusiastic citizen, partly as follows :—

"This case is typical and essentially requiring active treatment.

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 "It is most important that our health authorities should have the confidence of the community and be assisted properly, but——— cannot set the law in motion without your aid, if indeed they should ever assume such action.

"I have the hope that this letter when duly considered will prevent any uncalled for distrust of our health officers.

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 "I see where there is power that if not exerted our City becomes a dangerous community as compared with another protected by law."

Our attempts to deal with these cases by court proceedings have been discouraging. Personally I believe that such cases as this will always be a source of worry until we are able to commit them in some way similar to that of disposing of the insane or the habitual drunkard.

The financial end of the tuberculosis problem seems never to concern anyone except the local board of health. With a twelve dollar tax limit, and say six of that to go by law to the school department and three and a half to the police and fire departments, there remain but two dollars and a half for streets, disposal of garbage and rubbish, parks and health. Rigid economy is absolutely necessary. Whether the new law regarding the tax levy will help out remains to be seen.

The aftercare of the consumptive is important. It is a question if the discharged patient should be provided for by the board of health alone or by somebody more interested in the purely economic side of the question. It depends on the particular case. At all events boards of health should not be too severely criticised for failure to act until they are properly notified of the discharge of such patients.

I have indicated the more important phases of our problem. The remedy is not for me to suggest. Until the efforts of local authorities who do their best are more fully recognized, boards of health will remain on the defensive and those inclined to shirk will continue in aggressive. Apropos is the proverb, "You can lead a horse to water but you can't make him drink."

Some day, I hope, the health laws of Massachusetts will be simplified and codified not entirely by those who have no practical knowledge of the local authorities' point of view. I hope too, that we shall be treated fairly by all the State boards; that due consideration will be given the seriousness of the steadily increasing spirit of paternalism; and that we shall not be compelled by our law to provide a hospital for tuberculosis patients and be obliged by another law to pay for patients sent elsewhere at the will and pleasure of someone else. Persons whom we are supposed to control should not be able to say they will not do as we wish because they can pay their board a week or two at some other place and then stay on at our expense.

If we are to have responsibility let us have the authority and respect necessary for us to assume it properly.

REFERENCES.

1. Revised Laws, Chapter 75, Section 50; Acts 1905, Chapter 251; Acts 1907, Chapter 480.
2. Revised Laws, Chapter 75, Section 35; Acts 1906, Chapter 365; Acts 1911, Chapter 613; Acts 1912, Chapter 151.
3. Acts 1907, Chapter 474.
4. Revised Laws, Chapter 75, Section 43.
5. Folks: American Journal Public Health, II, No. 10, p. 776.
6. Callahan: Boston Medical and Surgical Journal, clxviii, No. 22, p. 794.

ARTICLE XXII.

NEED OF CO-OPERATION BETWEEN LOCAL
AND STATE FORCES IN TUBER-
CULOSIS WORK.

BY JOHN B. HAWES 2ND, M.D.,
OF BOSTON.

DELIVERED JUNE 10, 1913.

NEED OF CO-OPERATION BETWEEN LOCAL AND STATE FORCES IN TUBERCULOSIS WORK.

At the present time, there are many physicians who are declaring that the sanatorium movement is a failure. This is undoubtedly an extreme point of view; it would be far nearer the truth to state that our sanatoria are not accomplishing as much as they should. It is a matter of individual opinion as to how far short they are falling from the proper standard. In this paper I propose to discuss what I believe to be the great reasons for this shortcoming and to consider plans for betterment of the situation.

The two great factors which militate against good sanatorium results are *first*, lack of strict discipline and close co-operation between physician and patient while the latter is still at the institution, and *second*, lack of co-operation between the sanatorium and local forces, including first, the discharged patient and his family, second, the patient's physician, third, local tuberculosis organizations, and fourth, the local boards of health. It is this second factor, lack of co-operation between state and local forces, which is by far the more important of the two.

It is not difficult to outline on paper a plan whereby proper co-operation could be brought about. Among other features there would be embodied in such a plan careful and detailed instruction of the patient while in a sanatorium and when about to leave it; prompt notification and tactful advice to physicians and tuberculosis organizations, and, above all, a higher standard of effort on the part of local

boards of health which will force them to assume their proper responsibilities. Such a high standard would necessarily include periodical examinations of the patient and of his family, supervision of his work, the following up and keeping in touch with the wandering patient, and the proper control and segregation of the incorrigible consumptive.

Some of these measures are now in active operation on the part of the state. All local forces are promptly notified of the arrival of every patient; attempts are made, not as yet, I regret to say, with much success, to secure the co-operation of the patient while at the sanatorium, while on discharge every patient is examined and given friendly advice as to the future. In addition to this a letter is written to the patient's physician, in which his condition is fully described and suggestions made for future treatment. Copies of this letter are sent to the local board of health, the local tuberculosis association and the state board of health. The patient himself is also provided with a copy for his own use. This system, by means of which we are endeavoring to get in closer touch with local forces and discharged patients, is now in operation at each of the four state sanatoria and is already beginning to show good results.

That we still have a long way to go, however, will be shown by the following figures collected by Miss Bernice Billings, the social worker employed by the State Tuberculosis Trustees to follow up discharged patients. Miss Billings began her work July 23, 1912. These statistics are the results, therefore, of ten months' investigation on her part. During this time she has looked up 613 patients discharged from the State sanatoria. The table given below shows the exact figures. It should be borne in mind that the statements as to the present condition of these patients, good, fair, ill, etc., are not medical opinions but merely those of a trained social worker for whose general common sense and intelligence, however, I have a high respect.

TABLE IN REGARD TO DISCHARGED SANATORIUM PATIENTS.

Classification on Admission.		Condition at Miss Billing's Visit.						
		Good.	Fair.	Ill.	Died.	In San.	Not traced.	At Work.
Incipient.....	118	63	27	5	1	6	16	per cent. 73=61.8
Mod. advanced.....	213	67	72	23	11	16	24	102=47.8
Advanced.....	279	30	65	84	45	24	31	73=26.1
Not considered.....	3	1	1				1	2.
Total.....	613	161	165	112	57	46	72	250=40.7 per cent.

The important points in this table are that only 61 per cent of the incipient cases and 47 per cent of the moderately advanced are able to work while 26 per cent of the advanced cases are apparently able or feel that they are able to carry on some occupation. The comparatively low per cent of the incipient cases, 61 per cent and the equally large per cent of the advanced cases at work are surprising features. An investigation of these same patients a year later will be of great interest and value. Regarding the work of local boards of health, Miss Billings has found that in only 39 per cent of the 613 cases has the local board been known to clean up or fumigate the patient's premises while a still smaller proportion of the patients, 23 per cent, has received adequate advice or instruction from local boards.

From Miss Billing's careful survey of the situation during the last ten months in which she has had numberless interviews with patients and their friends, nurses, social workers, doctors, and boards of health, and from my own experience during the last eight years, during which time I have been intimately connected with this work, I have formed several very definite opinions on this general subject. The first is that patients as a whole are deeply appreciative of advice and attention given them after their discharge if this is

done quietly and tactfully; in the case of a few incorrigible patients advice of any kind is but time wasted; a strict law and a stern public opinion is the only thing which will meet this situation. Second, on the part of local boards of health it is primarily ignorance as to methods, and next lack of funds, which stand in the way of good work. In about one third of the cases lack of harmony between the local board of health and the local tuberculosis organization is a great handicap. Third, it is only in the rarest of cases that private physicians are not glad to have their patients helped and advised by our worker.

For the future, to further increase the efficiency of the state's warfare against tuberculosis, we hope to enlarge the scope of our present work, first, by a stricter discipline of patients while in the hospital, discharging, if necessary, those who will not co-operate, second, by introduction of more social workers inside and outside our institutions, third, by adopting a system of "experimental furlough," *i. e.*, discharging a patient on trial, as it were, and readmitting him without delay if he shows any signs of relapsing, and finally by establishing out-patient departments at each sanatorium where indigent patients can get free advice and treatment and discharged patients can come for periodical examinations and to report.

In addition to this, the gradual increase of local tuberculosis hospitals and particularly of efficient dispensaries will be of the greatest assistance. I doubt very much if the state alone should go further than I have indicated above. Local forces must meet state efforts half way. The problem of tuberculosis is after all a local one; only by the development of a strong public opinion in each community that tuberculosis is primarily a question to be met by local efforts, can the disease be successfully combatted.

DISCUSSION OF ARTICLES XX, XXI, XXII.

DR. WALTER C. BAILEY, Boston: I would like to say just a word to emphasize Dr. Adams' statement in regard to having this discussion general. I would like to listen rather than to speak; but there are one or two things in regard to Dr. Peirce's incisive paper that I have been trying to think about and wondering just what they mean. It seems to me that it comes down to the fact that in Dr. Peirce the Cambridge Board of Health has a most valuable and trained man in tuberculosis. Now if you can repeat Dr. Peirce all over the state you have the situation solved. A local board of health ought to be the board to which, for instance, our board can go in regard to everything in that city, not to the local tuberculosis society. I believe that is the answer to that. I do not see any better work that the local tuberculosis society can do in various towns and cities than to insist that there should be on the local board of health someone whose duty it should be to attend to the tuberculosis question. If that can be brought about it would be a great step in advance because we would have someone trained to recognize the difficulties as Dr. Peirce has recognized them and has pointed them out. It would relieve the clashing between the social worker or anybody else who is interested in tuberculosis and this feeling that everybody ought to do just as he thinks best; it would also relieve a lot of reduplication. I think that is one of the things which irritates me more about tuberculosis work than anything else — everybody doing a little something in one direction and then dashing off in some other direction. It is a criss-cross game which leads nowhere.

Secondly, I would like to state that the trustees of the state hospitals are studying and working at this question very hard indeed, and if anybody in this room has any ideas or knows of anybody who has any ideas in regard to the work of the state, or anything pertaining to this subject, we would be delighted to have him express them to us and would give them the most careful attention and most careful advertising that would be possible for us to do. I wish to insist upon that desire that we have to learn, to be helped, by anybody who sees the problem from a different angle from which we

see it. I do think that the tuberculosis work is improving. The whole affair today is of an entirely different color than it was twenty years ago, but it seems to me that we have arrived at a position now where particular care is needed to continue in the right direction. Dr. Hawes has spoken to you about the state sanatoria work, and I simply wish to touch upon an experiment that is being tried today at North Reading, in regard to the "Sanatorium Class" and the "Hospital Class"—dividing the patients into people who want to get well and those who do not want to get well. I believe this is going to be very effective in accomplishing what we wish to accomplish. Now in conjunction with that work, which is one of application and of intensiveness, if you wish to use that term, there is also the other side, that it turns the problem over to the people who are there at the sanatorium. To conclude, I believe that a great deal of work can be done by the tuberculosis societies and the local boards of health. First, have someone on the board who really knows about tuberculosis. Second, there should be in every tuberculosis society, either as its president, or on its board of active management, one, two or three members of each labor union in that town or village. Now you can talk to the people as much as you like, but you will never get the real forces at work until you get them to take hold of it themselves and work it out, because they approach their own people from a different angle from what we do. They look upon our work many times as interference where, from their point of view, if those workers would take it up, it would be received kindly. This is the effect we want to produce, but are often unable to bring about.

The third point is while we are doing this work, which must be now almost individual work, it has got into shape so that it cannot be treated *en masse* any more. We must have slow growth; it must be slow education, training of men and of workers, and slow education of people. There is one point in which I believe we could accomplish a great deal, that is infection from bovine tuberculosis. As you know, from 15 per cent to 20 per cent of the young children and young adults who develop tuberculosis probably are infected with the bovine bacillus. I think we could put in some effective work which would stimulate us and would be a point

towards which we could work with straightforwardness and feel that we were getting somewhere. That means probably the drinking of pasteurized milk, and if this conference could make a regular campaign for the use of pasteurized milk, and the careful eradication gradually of tuberculosis in cattle, I believe that that would be a thing very well worth while, and I should like very much to have this conference take up that work.

DR. ELLIOTT WASHBURN, Taunton: In a somewhat exhaustive study of some of the difficulties in the tuberculosis problem in Massachusetts, made last fall, a number of difficulties were found, three of the most prominent being as follows: First, the method of appointment of local boards of health. Local boards of health in small towns consist of the selectmen. Selectmen when they act as boards of health almost invariably are poor boards of health. They regard their public health work as a disagreeable side line to their other work; they are looking to their reelection, and they do as little public health work as possible. In larger towns and cities boards of health often are appointed as political rewards and they shift frequently, so that when a board does become familiar with its duties it soon passes and the work has to be done all over again. That we found to be a great difficulty in effective work in tuberculosis.

The second difficulty which we found was the lack of a central control over the whole tuberculosis situation in Massachusetts; some clearing house to which all the organizations or workers in tuberculosis may go for advice.

The third difficulty, and a great difficulty, was the lack of a specific, definite law by which the unteachable and incorrigible consumptives may be compulsorily isolated. For the passage of such a law we found almost a crying demand. The present law under which smallpox cases are taken forcibly and isolated has been resorted to by some boards of health, more especially the Board of Health of Boston. In other cities the boards of health have been advised by their city councillors that they cannot take such action, so that we find the boards of health are timid in taking such action. Only Sunday night of this week a board of health telephoned to me asking what to do in the following case: A woman

far advanced in tuberculosis persisted in spitting all about the yard; she lived in a large tenement house, and without doubt was endangering the rest of the people in that tenement. She absolutely refused to listen to reason. The board of health could do nothing with her. They asked if they could send her away. I told them they could; but first they had better obtain the opinion of their town lawyer. I told them not to send her away without so doing. There is need then of a definite, specific law whereby boards of health can take an incorrigible consumptive, when he does not regard the rights of his neighbors, is drunk half of the time, perhaps, who spits anywhere, and who absolutely refuses to listen to any of the demands of boards of health, and compulsorily isolate him.

Those three things stood out with special prominence: First, the inefficiency of some boards of health on account of the methods by which they are appointed; Second, the lack of a central control of the whole situation, and Third, the lack of this definite, specific law whereby incorrigible consumptives can be compulsorily isolated.

DR. E. O. OTIS, Boston: I think we are all familiar with the measures which have been presented to the legislature during the present session in regard to the tuberculosis problem in the state of Massachusetts, all tending toward the codification and unification of laws and unity of administration. Some of these bills have desired to put the whole matter, the whole tuberculosis problem, under the State Board of Health and give it absolute power to deal with it; others that the State Board of Health should have advisory power over all health matters and in addition definite administrative powers, and that under it the trustees of state hospitals should constitute a division which should carry on the whole tuberculosis work in this state. I think that one trouble in regard to the tuberculosis problem in this state is that there is uncertainty and a division of responsibility in regard to the execution of the various laws in connection with tuberculosis. It seems to me that out of all this agitation we shall have some day a more definite state arrangement by which the whole problem of tuberculosis shall be placed under either a commissioner, or, what would be more prac-

tical and which I favor, under the trustees of the consumptives' hospitals; so that everything relating to tuberculosis, supervision of voluntary and private local tuberculosis measures, the care of the state hospitals as now, the supervision of the local hospitals and of the prospective dispensaries, all should be under the supervision and the direction and administration of the consumptives' trustees. We all know that recently the state of New York has adopted a new code for its State Board of Health and they manage the tuberculosis problem by making it one division under the State Board of Health, and have appointed a single commissioner to be responsible to the head of the health department for the whole tuberculosis problem in the state.

It seems to me there are three distinct points which are uppermost now in regard to the fight; First, that of notification, which is not by any means satisfactory at the present time, and it seems to me it can only be made satisfactory by the physicians themselves. They have got to take more pains and more care in reporting cases. I fully recognize that there are a great many difficulties in doing it. If a case, for example, is reported in a well-to-do family and the board of health sends its inspector around a great deal of anxiety and worry is produced, and the physician often has to bear the brunt of the malediction of the patient and his family. I recall the case of a poor woman who was boarding in an apartment house who was visited by the inspector of the board of health, and the people with whom she was boarding immediately turned her out as a dangerous case, and she could not find any other place to go. I think that we should take great pains in reporting all our cases of tuberculosis. Of course there are various physicians and institutions who differ as to whether they shall report only those cases in which the tubercle bacillus is found, or whether they shall report all cases which they feel with absolute certainty have tuberculosis, whether or not tubercle bacilli are present. I wrote to the Boston Board of Health about this and they said "report every case which in your opinion is a case of tuberculosis."

Second, the matter of local provision for consumptives' hospitals. I agree with Dr. Hawes that this is a local question. Patients should be cared for by the local community

where they are near at home. In the case of the large cities many have their own local hospital for their cases of tuberculosis. You know doubtless of the so-called Fall River bill which has been introduced into the present legislature, one provision of which is that the state shall appropriate a half million dollars for taking upon itself the provision of these local hospitals. I believe that each section of the state should provide its own means for caring for its indigent, advanced cases of tuberculosis.

The third point which I do not believe is satisfactorily settled is the matter of efficient dispensaries. If we are going to find out these cases early we must have efficient dispensaries; dispensaries which are open in the evening, because a great many working people do not feel themselves sick enough to lose a day's work or half a day's work. The Trustees of the Boston Consumptives' Hospital have already voted to hold an evening clinic, and I believe they already have one in Springfield. The most important part of a local dispensary is the social visitor, infinitely better in my opinion than a mere trained or visiting nurse. The social worker should have some knowledge of tuberculosis, but I think from her general training she is far more valuable than a mere trained nurse. After the physician has examined the patient and expressed his opinion as to its disposition the social worker sees that those suggestions are carried out. If a patient has to go to a sanatorium she makes the necessary arrangements; when the patient is there she visits him; when he comes out she visits the patient again and brings him around to the dispensary and has him examined. She keeps track of him all the while; she never lets him out of her view. I think that is the most essential part of a dispensary.

I think it was Dr. Jones who suggested the value of advertising to bring the problem of tuberculosis home to the people. Dr. Barnes, the superintendent of the sanatorium in Rhode Island, read a very interesting paper recently in Washington, at the meeting of the National Tuberculosis Association, on this very point. I believe that we should advertise in our local papers in such a striking way that the attention of the people would be attracted to it, and if they have any of the symptoms which may be suggested, the most

important symptoms, they should be urged to consult immediately their physician or go to the dispensary. We might not only advertise in our various papers but if some charitably-disposed person were inclined to make a contribution, we could have advertisements in our trolley cars, in the places where other advertisements are put, giving some sort of suggestions which would attract the eye of the traveling public, stating that if they have any plain, leading symptoms they should immediately consult with their physician. In line with this the Boston Tuberculosis Association last year and this summer has instituted a series of lectures in the moving-picture shows in the city and surroundings. We have a capable lecturer who is sent around and almost invariably these 5- and 10-cent shows have been willing to give him seven minutes with his stereopticon views, to be put in between other performances, and in that way a large number of people have been reached. People will go to a moving-picture show and in that way they find out something about tuberculosis that they did not know before. I would like also to call attention to the moving-picture films which are supplied by the National Tuberculosis Association. They always attract attention.

With regard to the incorrigible consumptive, I daresay that some of you have had the same experience as myself, i.e., that it is not always the poor consumptive who is careless and hence dangerous. That is one of the difficult problems, that it is sometimes the well-to-do consumptives who through carelessness or whatever it may be, are not altogether safe consumptives. Some time ago I called the attention of one of the car conductors to a very well-dressed man who was expectorating on the floor of a car. Rather reluctantly the conductor went up to this gentleman and said: "You are spitting on the floor, sir," at the same time calling his attention to the no-spitting sign in the car. The man replied: "Sir, I am a gentleman and I have got trouble with my throat." The well-to-do consumptive sometimes, so far as the care of the sputum is concerned, is careless.

Dr. Hawes has referred to the physicians being informed of the discharge of patients from the sanatoria. There are many patients who have no physicians; they are sent from different institutions, dispensaries, hospitals, etc., so that

it is somewhat difficult in that way to get track of those patients if they are sent from a dispensary or hospital.

There is where your social worker comes in; she finds out at once when he comes back and she goes and visits him.

One point in conclusion, that is with regard to the further use of the sanatoria for training in early diagnosis and for better research work. There has just been inaugurated in the city of Philadelphia the Henry Phipps Institute for Tuberculosis. This is a model institution for doing research work. We have in each sanatorium in the state an admirable opportunity for research work. A good deal is being done already; but I think that the state could contribute more largely than it does if it would be willing to pay for workers in these institutions, pathologists, bacteriologists, etc. In this way I believe a great deal could be accomplished.

Further, with regard to early diagnosis, the suggestion is a good one that there should be, let us say, a week of schooling offered to the physicians, at a sanatorium. Various states have what they call schools for local boards of health in which the different health officers come together for two or three days where they profit by lectures and study in health matters. Now if an arrangement could be made by which certain groups of physicians could go for a week or ten days or two weeks and remain at the sanatorium to see the institution and to study the methods and especially early diagnosis there, it seems to me they would derive great benefit and so would the various communities in which they practice.

DR. ALBERT C. GETCHELL, Worcester: Two points I would like to speak of. While they are not definitely indicated by the program yet they are germane to the subject. We look upon this question as a problem and I think we are likely to lose sight of a very important fact, that while tuberculosis is a problem, yet the tubercular person is a sick person and should be considered so individually. This is the first point I wish to emphasize. It is said that in the crowded cities of Europe every one at some time has tuberculosis. While this is not true to such an extent with us, yet tuberculosis is much commoner than it is thought to be and is not the fatal disease it is commonly supposed to be. Indeed,

many persons get over an attack of tuberculosis without knowing they have had it. It is not a rare experience with me to find evidence of a healed lesion in the lung where there is no definite history of sickness to account for it. These patients consult a doctor for reasons of ill health with perhaps some symptoms pointing to tuberculosis. For instance, I recently saw a typewriter who consulted me mainly because she spat some blood. I am sure she had a healed lesion in the lung and that she would maintain the recovery she had made if she did not allow her resistance to run down.

Again, a person may have evidences of what we are accustomed to think active tuberculosis and still be in good health and able to work. Not to multiply cases, but to cite one in point, a man who has been under my observation for several years. Nine years or more ago he was definitely sick with tuberculosis and went to a sanatorium. Since he came back, now over eight years, he has been steadily at work in a department store. He has had slight hemorrhages and other evidences of disturbance from which he has promptly recovered, and has generally been in good condition and able to do his work. Part of the time he has had bacilli in the sputum. I have told him not to worry and gradually he has come to accept this advice and act on it. I think we are in danger of putting this class of people off by themselves as a menace to the community, a mistake, in my opinion. This is a state problem; but it is also a problem of sickness and one that physicians have to take up exactly in the way they do any other illness and advise the individual patient as to what is the best thing for him to do in his particular sickness: some to go to a hospital, some to a sanatorium, while others can keep at work under suitable conditions.

Closely connected with this thought is the second, so admirably emphasized by Dr. Peirce in his paper. And here you will allow me to quote Dr. White of Pittsburg, a capable man and one of large experience in tuberculosis matters. He read a paper in the recent meeting at Washington on "The Doctor and the Social Worker." It is not my purpose at this time to discuss the relation of the social worker to the tuberculosis problem. The problem is a complex one and we have to utilize every instrumentality society offers. But, I do want to emphasize the point that Dr. White brought

out, namely, that it is primarily a medical question and must be controlled by medical men, but yet it had got away from this control. He cited the fact that, while a large proportion of deaths was due to tuberculosis, little definite instruction in the subject was given in the medical schools. To show that the medical schools are beginning to realize their responsibility in the matter, he spoke of the recent acquisition by the University of Pennsylvania and the Jefferson Medical College of important tuberculosis dispensaries whereby this subject may be more adequately taught to their students. This shows a tendency in medical schools to realize their medical responsibility in the tuberculosis question. So, while tuberculosis is one of the great questions of society, it, as well as the care of the tubercular sick, must be under medical control.

DR. CHARLES E. PRIOR, Malden: I do not know that I can throw any light on the subject more than has been already shown, therefore, perhaps I had better speak of the situation as it appears right at home. In Malden we are trying to fit in as a cog in the big wheel of progress and to carry out the program as outlined by the state at present. I have been sorry to see any attempt to change the law on this subject, particularly the Fall River bill seemed a step backward. It seems to me we have plenty of law at present and what we want is to go ahead and carry out the law. If we try to get more legislation we shall be at sea all the time. It seems to me that we have the authority and it is up to us to follow it. That is what we are trying to do in our little town.

DR. F. H. FULLER, Walpole: I would like to speak on one matter, that of bovine tuberculosis. I happen to have knowledge of a certain district in this state where the local inspector of cattle has been accustomed to condemn an animal and then his superior in command would release that tubercular animal. The result would be that perhaps after a considerable time some of the Jewish dealers or others would buy that animal and send it in to Brighton and thus it would get into the food supply. It seems to me that this is a matter which needs attention. It would appear that

the Board of Animal Industry is at fault, and if this happens in one district I am sure it will happen in another.

Another matter is the notification of a tubercular patient's removal from one town into another. This should be much more general, so that if a patient moves from one town into another, or the physician changes, the proper authorities should be notified so that immediate health measures may be taken. As a result, local boards of health are apt to be very lax in following up these cases, in giving advice, and disinfecting when needed. I think when we get our organization as thorough as it should be that the local board of health will disinfect where required and follow up every case not only for one year but for several years so as to know what progress, if any, has been made, and to see that these people do not become so great a factor in the dissemination of this disease.

DR. BAILEY: I would like to ask Dr. Fuller what he considers to be the dangerous factor in bovine tuberculosis?

DR. FULLER: It seems to me that where such cows are giving milk the milk might be infected and would very likely be given to children.

DR. BAILEY: It was not the idea of meat?

DR. FULLER: No, sir, not so much, so far as infection is concerned.

DR. I. J. CLARKE, Haverhill: I just want to refer to three or four points. It seems very necessary that a state law be enacted making it mandatory for boards of health to disinfect the same as they do in a smallpox case or any other infectious disease. So long as it is left to the board of health, unless the law is mandatory, we shall be a long time in getting the sort of disinfection which we need.

I also hope that there will be a thorough and early understanding between either the State Board or the Trustees of Consumptives' Sanatoria in relation to the new hospitals that are being constructed by the local towns and cities. Quite a number of them are now nearing completion, and I know in our town there is not very much interest being taken. It is said it will be ready to open in a month. I

know that it will take more than a month to arrange things, to get physicians and trained nurses and so on to command an institution of that kind.

I want to speak of something that has not been mentioned here in general discussion and that is the use of the clinical thermometer in early diagnosis. I find it of the greatest importance in finding out in obscure cases what the matter is, and I am enlightened very often by getting the temperature. It is my rule to furnish a thermometer to patients and request them to bring me in the temperature taken four times a day — most of them are quite willing to do this. The results are certainly very instructive.

I would also like to see foreign printed matter furnished by the state. In our town it could be easily distributed among the local sick-benefit societies. There are a lot of people who cannot read our English-printed papers and they have no means of knowing anything about what is going on. On my desk I have some pamphlets printed in Italian. I find that the Italians are very glad to look over them, and if they were printed in several languages it would be a great help. If they were furnished I think the Tuberculosis Societies in the several towns and cities would be very glad to distribute them.

I am in favor of the advertising scheme, the same as the quacks advertise in the newspapers and draw their victims. We ought to advertise in some way and draw to the attention of the people what the symptoms are in early tuberculosis.

I know of one town, it seems to me it is Salem, where they have had the best results in the dissemination of knowledge in regard to the prevention of tuberculosis in their lectures to the school children in the 9th and 10th grades and the High School. It seems to me that the impression which you make on the young children lasts much longer and is more deeply founded.

One other point in trying to establish an early diagnosis: So many patients say no one in the family had had tuberculosis, they don't know of anyone with whom they have been associated who has had it, but you notice that insurance companies are very anxious to ask the question: "Have you been associated with any person during the past year

who has had tuberculosis?" Insurance people are a great deal shrewder than we are in making this inquiry.

DR. GETCHELL: I suppose Dr. Clarke knows that this material printed in different languages is for sale in New York, I don't know exactly where, but I think you can buy them at cost from the National Tuberculosis Association.

DR. ARTHUR K. STONE, Boston: The National Tuberculosis Association provides literature in 27 different languages and it can be had on application for \$1.88 per 1000.

DR. JOHN B. HAWES, 2nd: I would like to make a few remarks about Dr. Jones' and Dr. Peirce's papers. In the first place Dr. Jones' statement about the lack of teaching. I want to emphasize that very much. In the Harvard Medical School at least I cannot see that the fourth year man when he graduates has had any practical experience whatever as to how tuberculosis is handled as a state problem or to any extent in private, as a big problem or as a little problem. It seems to me this is one of the missing cogs in our system.

About the visiting nurses, that was one of Dr. Arthur Cabot's hobbies — that the school nurse or the school social worker was the most important factor in the whole campaign.

When I got through the Massachusetts General Hospital in 1904 one of the regular jobs which all of us young men in Boston had was to go around to Trade Unions and the various lodges and give talks on tuberculosis and the Boston Association used to give us the material for these talks. I do not know why it is not done nowadays. It seems to me it was a very necessary thing to do. You cannot now get the young men to do it. I have been practically in every large city in this state.

Dr. Peirce in making his statement about the \$4.00 a week at the state sanatoria and the \$10.00 and \$15.00 a week at home, did not mention the state subsidy of \$5.00 a week which takes that much off the cost of the local sanatorium. He ought to have mentioned that \$5.00 a week which the state pays back for local support.

I should like to ask the question of the local men about the reporting of cases when a man sends you a case in con-

sultation. Is it courteous or right or proper to report those cases? I talked with a prominent physician of the State Board of Health and he said he would advise me not to report those cases. That brings up a question which is not settled in my mind.

DR. E. O. OTIS: The other day when a case was referred to me by some other physician I supposed naturally that he had reported it until I received a communication from the Boston Board of Health asking why I did not report that case. It seems to me that it is best to report all cases.

DR. BRADFORD H. PEIRCE: Dr. Hawes mentioned the \$5.00 a week subsidy. I should like to say in answer to that that we never know what patients we are going to get subsidy on. When a case is reported we try to provide for it. Then if it comes within the rules which the trustees have laid down for obtaining the subsidy we go for it, but even in the case of the patients for whom we receive subsidy we get no direct benefit. The check is made out to the city. This is in Cambridge of which I am speaking, and the Board of Health gets no really direct use of the subsidy.

SYMPOSIUM ON DISEASES OF THE
GALL-BLADDER.

ARTICLES XXIII AND XXIV.

ARTICLE XXIII.

CONDITION OF THE UPPER REGION OF THE
ABDOMEN IN RELATION TO DISEASE
OF THE GALL-BLADDER.

BY CHARLES G. STOCKTON, M.D.,
OF BUFFALO, N. Y.

DELIVERED JUNE 11, 1913.

CONDITION OF THE UPPER REGION OF THE ABDOMEN IN RELATION TO DISEASE OF THE GALL-BLADDER.

It should be possible to make a diagnosis of disease in the right upper quadrant of the abdomen without having resort to surgical exploration.

No statistics exist which show the proportion of unsuccessful surgical explorations. Data for such statistics are not to be procured, for many such explorations are made by men of low ideals, and men of low ideals do not report their failures.

There is the widest difference between good surgery and bad surgery, but there is an equal disparity between good and bad diagnosis.

An indifferent clinician and a surgeon who makes a "roving expedition through the abdomen" are natural associates.

It is necessary to strive, and to keep striving, for perfection in diagnosis. As proficiency increases the purely exploratory incision will become unpopular. This paper deals with disease of the gall-bladder and with other pathological conditions of the right upper quadrant of the abdomen which to the clinician may offer difficulty in diagnosis.

Cholecystitis and allied conditions, duodenal and pyloric ulcer, appendicitis, cancer of the stomach with metastasis to the liver, cancer of the ascending colon, slowly perforating peptic ulcer with abscess, some cases of syphilis of the liver, septic endocarditis with secondary infection of the liver and biliary apparatus, affections of the pancreatic head and, occasionally, septic right kidney represent the group of

diseases which often, either in origin or in attending symptoms, are related to the right upper quadrant of the abdomen. These conditions may puzzle the diagnostician.

Important among the causes of obscurity in diagnosis are :—

(a) The development and persistence of symptoms in an organ as results of disease in another, usually, but not necessarily, contiguous part.

(b) Comparatively trivial local disease accompanied by severe and misleading symptoms; or, the reverse of this.

(c) The simultaneous presence of two diseases.

(d) The influence of diathesis and metabolic peculiarities not only in the inauguration of symptoms, but also in masking conditions and in delaying recovery.

Permit me to consider these divisions of the subject in order.

1. THE APPEARANCE OF SYMPTOMS IN ONE ORGAN WHEN THE TROUBLE IS LOCATED IN ANOTHER.

For the most part these symptoms arise (a) because obstruction at the site of disease interferes with the function of some related part; or, (b) because irritation at the seat of disease, acting through the nervous system excites disturbances of function in other parts. Such irritation may be transmitted directly through a nerve, or it may act reflexly; the impulses may follow through the spinal axis, through the sympathetics or more particularly through the division of fibres now spoken of as autonomic nerves. (c) Secondary infections or metastasis may give rise to local symptoms of such importance that the primary disease is overlooked.

Among the familiar obstructive causes are enlargement of the head of the pancreas, opposing the flow through the ductus choledochus; ulcer, inflammation and edema, or growth in the duodenum, leading to swelling and closure of the common duct; tumor or inflammatory bands inter-

fering with the course through the biliary or pancreatic passages, the duodenum or pylorus; narrowing of the intestine impeding the flow through the intestine above as well as through the stomach and other tributaries.

Of nervous and reflex causes of symptoms that arise in parts more or less remote from the organ diseased, the most familiar one is that which, acting through the autonomic nerves, produces vagotonic excitement and spasm or overtonus of the pylorus and stomach. The familiar symptoms of this are severe pain, a sense of epigastric tension, sour regurgitations, eructations and vomiting.

Here are the stomach symptoms, yet no stomach disease may be present. The actual disease may be duodenal ulcer, cholelithiasis, appendicitis, perityphlitis, etc. At times it is not easy to determine that the stomach is free of disease and merely affected with derangement of function by a bombardment of nerve impulses arising in disease and irritation in another organ.

When it is concluded that the gastric symptoms do not result from gastric disease, it is yet frequently difficult to decide from what organ the storm of nerve impulses is coming.

Obstruction and nerve irritation may act conjointly, and the symptoms which result may closely resemble those produced by general infection or metastasis. The value of these statements may appear in the following closer examination of the subject.

Obstructive Causes. When bile is secreted under pressure greater than the blood pressure in the hepatic vein, jaundice results; therefore, slight obstruction is sufficient to produce cholemia, even when bile appears in the stools. Jaundice may develop suddenly or very gradually; and may be persistent or intermittent.

These facts may be turned to diagnostic advantage.

A sudden and complete retention of bile, usually inter-

mittent and accompanied by severe pain is justly attributed to stone in the ampulla; yet the same clinical picture may result from stone held in the cystic duct. However, in the latter case the pain is often more spasmodic and intense and the bile retention remains complete for a longer time, receding more slowly than when caused by stone in the ampulla.

Pressure from without, as in enlargement of head of the pancreas, leads to continuous and complete retention of bile, usually without pain. Often, following Courvoissier's law, it is accompanied by an enlarging gall-bladder.

Duodenal ulcer may involve the bile papilla and thus occasion jaundice; often this is associated with intense paroxysmal pain, with exaggerated duodenal reflex and consequent pyloric spasm. Probably, in some cases, the gall-bladder is also excited to spasm. The diagnosis may be established by having resort to the string test of Einhorn. Friedenwald and Baetzer report that the Roentgen-ray shadows display a rapid emptying of the stomach and duodenum. It may be safely affirmed that this is not uniformly true. At times the pyloric spasm is so great that nothing passes the pylorus for hours together.

When that exceptional disease, cancer of the duodenum causes jaundice, the icterus may appear abruptly or slowly, but the cancer at the same time produces the well-known symptoms of duodenal block and food stagnation.

Slowly developing jaundice may follow angiocholitis, and the infection on which it depends often induces cholecystitis. Such a process must not be assumed until there have been excluded the various diseases of the liver that may cause obstruction; that is, the various types of hepatic cirrhosis, syphilis, cancer and abscess. Cirrhosis may be excluded readily; not so the other diseases. The question of syphilis is often troublesome notwithstanding the employment of the Wassermann reaction. Syphilis is the contributing factor, if not the sole cause, of most of hepatic

cirrhosis occurring in hospital wards. My view point as to the frequency of syphilis of the liver has changed within the past few years. Most cases of those formerly regarded as hopelessly incurable are now subjected to a prolonged and intensive course of treatment with mercury and Salvarsan, and the proportion that makes improvement is astonishing.

Occasionally a gumma obstructs the choledochus or cystic duct, and though more often mistaken for cancer, the symptoms may closely resemble those of cholecystitis.

Abscess of the liver would scarcely be mistaken for disease of the gall-bladder; yet amebic abscess, forming about the transverse fissure, may produce symptoms that are very suggestive of cholecystitis. Abscess in the region of the liver, but outside that organ, may give rise to much perplexity. Abscesses of this kind, as a rule, are secondary to slowly perforating ulcer. Ordinarily a fistulous tract is formed and this may follow in various directions, governed largely by the point of perforation. Perforating the anterior surface of the stomach or duodenum, an ulcer would probably result in an anterior phlegmon; or, the process may pass above the liver and form a subphrenic abscess. Perforation of the posterior wall of the stomach would lead to abscess in the lesser omental cavity. A posterior perforating ulcer of the duodenum is prone to penetrate the retroperitoneal tissues, to burrow downwards along the psoas muscle, and to form a deep abscess, the origin of which is readily misinterpreted.

The immediate symptoms of perforation of the stomach, duodenum or gall-bladder may be mistaken one for the other and, through protecting adhesions the process may be converted into a very chronic one and be difficult of differentiation. I have seen cases in which the diagnosis was missed, even after exploratory incision, in which the patient survived for months and in which large collections of pus eventually were evacuated. One case which came to me had been

diagnosed first typhoid fever, then tuberculosis and finally cholecystitis. A large abscess was recognized which on drainage was shown to occupy a space above and behind the liver. Apparently it arose from perforation at the lesser curvature of the stomach. Ordinarily such a perforation would produce only the comparatively frequent subdiaphragmatic abscess. In this case the abscess was drained posteriorly.

Another case probably arose from latent duodenal ulcer. After long study by several men, first the appendix was removed, then the gall-bladder was drained. There were many adhesions in the upper right quadrant; the patient was not relieved of his septic condition. Later, there developed symptoms of psoas irritation, and a retroperitoneal abscess with a sinus extending upwards and behind the liver was drained through the incision just above the pelvis. In this case ulcer has not been suspected. After removal of the appendix, the obscure symptoms in the right upper quadrant attracted attention to the gall-bladder, which was unnecessarily drained.

These details are given in order to emphasize the fact that many obscure cases representing signs and symptoms in somewhat distant parts, have their origin in the right upper quadrant and usually result from perforating ulcer.

Thus the right and left pleural cavities, the mediastinum, the pericardium, the greater and lesser peritoneal cavities and the retroperitoneal structure may finally bear the brunt of the disease. However, there is often a strong temptation to make the diagnosis of cholecystitis and to advise a cholecystostomy.

Cancer of the liver usually also means primary cancer of the stomach, yet at times the gastric disease is masked, and the symptom complex often strongly suggests cholecystitis. Jaundice may be absent, or, if present, it may be of various degrees of intensity, and may appear slowly or abruptly. The obstructive symptoms may duplicate precisely those

of cholecystitis and gall-stones. The differentiation is usually made from the cachexia, together with the character of the stomach contents and the gastric symptoms.

The gastric cancer may be latent and easily overlooked. When a new growth springs from the submucosa, it may give rise to symptoms and to gastric contents that closely resemble those of achylia gastrica. When the biliary tract or the liver shows signs of disease, the contents of the stomach should be thoroughly investigated and, should there be marked depression of the gastric secretion, cancer should be suspected.

Malignant endocarditis in its symptomatology may closely parallel that of an infected gall-bladder. Often there is the absence of the more distinctive features of endocarditis; the liver is enlarged, and there is tenderness and muscle spasm over the gall-bladder, associated with fever and leucocytosis; a group of circumstances that may lead to a useless drainage operation. In such cases I have seen the gall-bladder drained, and the kidney, the retroperitoneal structure and the lesser omental cavity explored with negative results. Not until autopsy was a correct diagnosis made of septic endocarditis. Sometimes a differential diagnosis is most difficult. Blood cultures often are negative; the bacteria apparently being strained out of the arterial blood and lodged in the tissues, when they give rise to cloudy swelling and edema in the liver, gall-bladder, kidneys and other organs. Undoubtedly in such cases, when the venous blood is found negative, cultures should be made from arterial blood.

2. COMPARATIVELY TRIVIAL LOCAL DISEASE ACCOMPANIED BY SEVERE AND MISLEADING SYMPTOMS.

Just as it is possible for gross lesions to be present, yet attended by inconspicuous symptoms, so also local disease of minor importance, such as chronic appendicitis, stone in

the bladder, movable kidney, or renal calculus may occasion marked symptoms in the right upper quadrant of the abdomen. This development of marked symptoms from moderate and perhaps distant causes is to be attributed to vagotonic irritability, native to certain individuals.

In the case of the gall-bladder, there may be characteristic signs and symptoms of chronic or even acute cholecystitis; muscle spasm, tenderness, hepatic dulness, leucocytosis, besides severe pain, vomiting, sour stomach and other expression of pyloric spasm, collectively of sufficient importance to warrant operation and drainage; yet upon examining the exposed gall-bladder it will be found normal in appearance and to have normal contents. I have seen cases in which the only abnormality discoverable was the presence in the gall-bladder of greenish fluid, having too great consistency; no evidence of past or present inflammation, apparently perfectly healthy organ, with a patulous cystic duct. Such patients I have seen permanently cured by drainage of the gall-bladder, after they have resisted a long course of treatment, including dieting, rest and other soothing measures. The nature of such cases is rather mysterious. It would seem to be straining a point to explain the concurrent symptoms by assuming a derangement of the vagal or sympathetic nerves. A more probable explanation may be found in metabolic disturbances, hereafter to be considered.

The gall-bladder may show striking deformity from chronic inflammation, and yet produce but moderate and indefinite symptoms. This occurs when the cystic duct is permanently closed and when the content of the gall-bladder is sterile. I have seen a case in which the gall-bladder at operation was found to contain large calculi, besides a collection of sterile, "puruloid" fluid; evidently it had been bile-free for a period of years. The walls of the viscus were one centimeter in thickness. Yet in this case there was not much suffering. There was occasionally pain, for the most

part epigastric, less often infracostal; at times there was sensitiveness to pressure and muscle spasm. There were the usual symptoms of an irritable pylorus, distress after meals, hyperchlorhydria and delay in emptying the stomach. All symptoms disappeared after cholecystectomy.

On the other hand, when the gall-bladder is infected and, when from time to time it becomes congested and swollen, when its spasticity is exaggerated, when the autonomic nerve fibres are highly irritable, then the suffering is likely to be intolerable. In cases of this kind the diagnosis may be difficult for the reason that the vagotonic symptoms may be conspicuous and give rise to a clinical picture that resembles duodenal or pyloric ulcer as much as it does cholecystitis.

Under these circumstances, the "string-test" of Einhorn is very useful for, by having recourse to it, ulcer may be excluded in cases wherein the anamnesis and the results of examination of gastric contents may leave one in doubt. Sometimes valuable information may be derived from radiography.

After cholecystitis, the resulting adhesions often hold the duodenum, the pyloric extremity of the stomach and the hepatic flexure of the colon in a fixed and unnatural position.

3. THE SIMULTANEOUS PRESENCE OF TWO DISEASES.

It is an experience not very rare to find cholecystitis and appendicitis, or cholecystitis and duodenal ulcer simultaneously present, or some other combination in which more than one cause is operating to produce the symptom complex. When a course of medical treatment or surgical drainage is carried out for the relief of symptoms of cholecystitis, it is embarrassing to find the symptoms continuing with their former intensity. The fact that two causes are jointly responsible for a symptom complex may not be discovered until one of these has been eliminated.

A colleague, coming from a distance, suffered from symptoms which I attributed to cholelithiasis. The gall-bladder was drained and many calculi removed, after which the patient promptly gained in weight and general health, though he continued to suffer from hyperchlorhydria and recurrent pyloric spasm. Duodenal ulcer was suspected; soon afterwards came profuse hemorrhage, following this persistent vomiting. Owing to the spasm and vomiting the "string test" and duodenal feeding were not successful.

The abdomen was opened and a dense adhesion, which appeared partially to obstruct the duodenum, was removed. The duodenum presented no visible or palpable evidence of ulcer. The patient survived two weeks, then died of exhaustion and acidosis.

The autopsy revealed a posterior duodenal ulcer, immediately below the pylorus, not discoverable without incising the intestine. In this case three causes were at work, any one of which might have produced all the symptoms, excepting perhaps that of hemorrhage.

It is occasionally inadvisable to make an unreserved diagnosis as to a single, local cause of irritation producing a symptom complex. When practicable the "string-test" should be employed; careful search for occult blood should not be omitted, and a full acquaintance should be made with the gastric function by means of the stomach tube and the Roentgen rays. After having taken advantage of these sources of information and, after having used this information judiciously, there yet remains, in a few cases, good reason for perplexity.

Doubtless light may be thrown upon some of these obscure problems by trying out the possible "vagotonic" or "sympathetico tonic" state of the patient, according to the method of Eppinger and Hess.

In attempting this I have met with some interesting results, but I feel that much experience and thought are

needed before conclusions should be drawn. Many cases need to be reported and analyzed, together with results of treatment, or post mortem findings.

In a desperate case in which the patient nearly succumbed to vomiting and starvation, and in which the radiograms pointed to perigastric adhesions, possibly neoplasm, at the pylorus, there were grave counter indications to a laparotomy. This apparently dying patient was unexpectedly and promptly relieved by $\frac{1}{8}$ grain of atropine hypodermically. Also I have succeeded in relieving gastric spasm and spasm of the gall-bladder, even when there was marked local irritation, as shown later by exploration, through the subcutaneous use of adrenalin. Probably the purely neurotic cases may be excluded by following the suggestions to be found in the work of recent pharmacology.

4. THE INFLUENCE OF DIATHESIS AND METABOLISM.

I predict a revival of an antiquated conception of the nature of gall-bladder diseases, feeling convinced that there is greater promise both of preventive and curative results than is now usually admitted. Following the work of Naunyn, Riedel, Magnon and others, we readily accepted the doctrine that gall-stones were the offspring of cholecystitis and that the latter was the consequence of infection. Of this relation of cause and effect, there can be no doubt, and yet it is but a part of the truth. This generation is occupied with the questions of infection and of surgical drainage. It is rather oblivious of the multitude of spontaneous recoveries and those effected by the Carlsbad and other cures. Little practical advantage is taken of the teachings of the ages that gall-bladder disease belongs to later life, to bodily inactivity, obesity, pregnancy, gluttony. These commonplace observances have been routed from the field by scientific data, and the ground is held by the idea that infection is present and that it is curable by operation.

It is well to inquire, why does the gall-bladder lose its immunity? Why is it invaded by pathogenic bacteria? The answer to these queries, even though it involves more specific agencies, includes diathesis and metabolism.

A sufferer from infection of the urinary tract may fail to improve with antiseptics or vaccines, but when diet, baths, recreation and open air life are added to the course of treatment, immediate improvement is to be observed. Similar facts are true of diseases of the gall-bladder. It is particularly true because of the close relationship between the gall-bladder and the liver, and the liver, more than any other single organ, feels first the evil results of metabolic deficiency and the harmful effects of the lithemic and gouty diathesis. One must have lived long to recall the importance once attributed to latent gout, to lithemia and to oxalemia. However, these neglected subjects were, and yet are, worthy of closest study.

This generation will scarcely listen to one who advises a course of colchicum, alkalies, a diet scientifically prescribed, systematic diaphoretic baths, massage and out of door exercise in the cure of infection of the urinary or biliary tract, but surely the time is at hand when the obscure subjects of gout, oxalemia and other metabolic defects will stand again in the foreground, not only in explaining pathogenesis, but in guiding our therapeutics.

Recently Loeper of Paris* has shown by experimental work that oxaluria depends on oxalemia; that oxalemia is demonstrable by blood examinations; that this condition alone produces gastro-intestinal conditions that might well be ascribed to infection of the appendix or gall-bladder, or to peptic ulcer. Latent gout and oxalemia are astonishingly frequent manifestations in Americans, and it would seem

* *Leçons de Pathologie Digestive, deuxième série*, Masson et Cie. Paris, 1912.

that we must retrace our steps and give these subjects more active consideration. This is true as to their relationship to the diseases of the digestive tract and especially to cholelithiasis, appendicitis and to other gastro-intestinal states now too exclusively attributed to infection or to vagotonic irritability.

It must not be supposed that I advocate a retreat from a hard-won position, or that the importance of infection is minimized. It is intended to emphasize the notion that infection may be but a corollary of diathesis and faulty metabolism. The statement is ventured that these questions of vital chemistry, although now much disregarded, bear an important relation to immunity, and should be considered in cases which to-day are immediately and conclusively relegated to the domain of infection or of the neuroses.

ARTICLE XXIV.

ERRORS OF DIAGNOSIS IN GALL-BLADDER
DISEASE FROM A SURGICAL POINT
OF VIEW.

By JOHN H. GIBBON, M.D.,
OF PHILADELPHIA, PA.

DELIVERED JUNE 11, 1913.

ERRORS OF DIAGNOSIS IN GALL-BLADDER DISEASE FROM A SURGICAL POINT OF VIEW.

To state something as "a fact" and to prove it are two different things and so also it is often easier to make a diagnosis than to confirm it. The surgeon much oftener than the physician is asked to prove his conclusions by his findings so that his point of view may be a little different from that of the internist. The beginner both in medicine and surgery is much surer of his diagnosis than he will be later when experience has taught him how much one condition can simulate another. Even the "typical" case occasionally turns out to be something quite different. This I am sure is the experience of us all. But I am not here to make excuses for our mistakes or to pretend that a correct diagnosis cannot, as a rule, be made. When the Chairman of the Surgical Section honored me with your kind invitation to read a paper on gall-stones I tried to think of some new ideas that I might bring before you, or some unique, interesting cases that might be made the basis of profitable discussion, but neither idea appealed very much to me or seemed to offer anything of novelty. When I think of Boston surgery I am apt to call to mind the work and words of two men recently among you and for whose ability and honesty I had the highest regard. I refer to Maurice Richardson and John Munro and I concluded that if I should emulate them I would present to you my mistakes rather than my successes, hoping that by a study and discussion of them we might be materially benefited. I have, therefore,

searched my operation records for the cases in which I expected to find gall-stones and did not, or in which I had made some other diagnosis only to find that gall-stones were the cause of the patient's suffering. The latter mistakes are much less frequent than the former. Our errors may, in the light of what is found at operation, be clear to us and it is evident when and how we went astray, but there will still remain cases which cannot be cleared up quite so easily.

A history of indigestion which manifests itself soon after eating by a sense of fullness and the eructation of gas; by attacks of pain of sudden origin in the upper right quadrant passing across the abdomen and around to the back and perhaps to the right shoulder-blade, and which are relieved by vomiting; and the finding of marked localized tenderness on palpation when the patient takes a deep breath; certainly suggest gall-bladder trouble. If we have added to these severe colic requiring morphia for relief and followed by a transient jaundice, we are quite justified in making a diagnosis of gall-stones. We have learned, however, that a patient can have all of these and still not have stones.

The following cases do not represent all of my difficulties, but I found by going over my records for the past four or five years I could get enough cases to illustrate our usual errors. The notes are my own made just after the operations.

Case I. Miss Z. Nurse. Jefferson Hospital. Cholecystitis? Exploratory. 11-7-'12.

I saw this nurse two or three months ago with Doctor McCrea; at that time she had been taken sick apparently with a laryngitis and after a day or two developed pain in the upper right quadrant of the abdomen accompanied by a leukocytosis of about 25,000. At the time I saw her she had no fever, but there was marked tenderness over the gall-bladder; no mass could be felt and there was no rigidity; she had no urinary symptoms and the urine was normal on repeated examination. Under rest and ice she gradually

recovered and the leukocytosis disappeared. She then had her vacation and returned to work some weeks ago. Two days ago she again complained of pain in the right upper quadrant and although her temperature was normal and has remained so, she had a leukocyte-count of 19,000. Her pain is located just below the costal border, but there is no rigidity and no mass to be felt. She says there was some radiation of pain to the right shoulder. The case did not look like a typical one of gall-bladder infection and I thought she might have an infection of her kidney but the urine was absolutely normal. Doctor McCrea thought that she ought to be operated upon, as he did in the first attack. I opened the abdomen through the right rectus and found the gall-bladder, stomach, duodenum, and the cystic and common ducts perfectly normal. There were no adhesions anywhere; the gall-bladder was moderately distended but easily emptied and I could find nothing to account for the patient's pain. The appendix had been removed two years ago and I felt no adhesions or other trouble in the appendix region. In order to make sure regarding the condition of the gall-bladder I emptied it, and obtained apparently only normal bile. Some of the bile was sent to the laboratory for examination. The gall-bladder was closed without drainage.

11-14-'12. The patient is making a very satisfactory convalescence, is free of pain and her leukocytes are 15,000.

5-30-'13. Has been much better and has attended to her work as a pupil nurse until a few weeks ago when she had another attack similar in all respects to the others, though the leukocytosis was not so high. The attack slowly subsided and she is now apparently well again.

I do not know to what the symptoms were due in this case, but notwithstanding the negative findings at operation and the absence of growth from the culture, I shall always regret that I did not drain the gall-bladder.

Case II. E. M. 37 Yrs. Jefferson Hospital. Gall-stones (?). Exploratory. Appendectomy. 11-2-'12.

This man gave a history extending over a number of years which strongly suggested gall-stones, but he spoke no English

and it was extremely difficult to get through an interpreter, a satisfactory history from him. He complained of pain in the right side of the abdomen at a point a little low for the gall-bladder. There was no appendiceal tenderness, there were no urinary symptoms and the urine was normal. There was nothing typical about the patient's description of his symptoms and the most marked feature in the case was localized tenderness. As he had been complaining a number of years, I thought I was justified in making an exploration of the upper abdomen. I opened the abdomen through the right rectus and found a distended gall-bladder with some light adhesions between it and the colon. The ducts were apparently normal; the stomach and duodenum were also normal. I had no trouble in bringing the appendix into the wound and found it short and free from adhesions; it was removed; the stump being ligated, cauterized and buried. I could feel no stones in the gall-bladder, but as it was so distended I concluded that I ought to empty it; I did so and found it contained only normal bile. The opening was closed and the wound closed without drainage.

11-19-'12 Wound infected mildly, some bile discharged, but patient comfortable.

6-10-'13. Patient made a good recovery, but I have been unable to learn his present condition.

In this case, too, because of the adhesions I should have drained the gall-bladder instead of closing it. Nature, however, completed the operation by establishing drainage.

Case III. J. W. 37 Yrs. Jefferson Hospital. Cholecystitis. Chronic Appendicitis. Cholecystostomy. 5-10-'13.

Patient is married and has two healthy children. Both parents living and well. One maternal aunt died of tuberculosis. When eight years of age patient had quite a severe attack of typhoid fever. At the age of sixteen he had another attack which was thought to be typhoid. His present trouble began with indigestion and stomach trouble eighteen months ago. Several months ago he began to have attacks of cramp-like pains and has had five. The pain was epigastric and passed along the right costal border to the back and occasionally up between the shoulder blades. He

did not vomit during the attacks. He says he was deeply jaundiced several months, about a year ago; no jaundice followed the recent attacks. He never had any chill or fever during the attacks. The bowels are usually constipated and movements have been very light. He has lost about 50 pounds in the last 18 months. Examination showed quite marked tenderness over the gall-bladder and nothing else. I made a diagnosis of gall-stones and advised operation. I opened the abdomen through the right rectus. The gall-bladder was large, soft and non-adherent; I could feel no stones in it nor in the ducts which were carefully examined. The stomach, duodenum, and pancreas were perfectly normal. I had little difficulty in bringing the appendix up in the wound and found its distal half twice as thick as the proximal and the vessels over it prominent and tortuous. It was removed, the stump being ligated, cauterized and buried. Although there was undoubtedly a chronic appendicitis, I did not think it could have produced the symptoms. The history was so suggestive of gall-bladder disease that I determined to examine the interior of the gall-bladder. The bile was thick and dark and contained some mucus; it was sent to the laboratory for culture. The mucous membrane of the gall-bladder was very red, thickened and rough. It looked like a strawberry gall-bladder without the stones fixed to the mucous membrane. A cholecystostomy was done.

6-10-'13. Good recovery; is gaining weight and looks much better. No growth from the bile.

My experience in the preceding cases was my main reason for draining this gall-bladder.

Case IV. Mrs. B. 36 Yrs. Jefferson Hospital. Gall-stones. Exploratory. Appendectomy. 1-1-'13.

The patient's physician sent her in with a diagnosis of gall-stones, saying she had had a number of typical attacks, and the history the patient gave certainly suggested gall-stones. Patient has a simple goitre but comes to the hospital because of the acute attacks of pain in the abdomen extending over two months. The first attack occurred at night and was of three or four days duration. The pain

started in the left hypochondrium, extended across to the right and then up the back to the right shoulder. The patient has had twelve attacks altogether and has vomited in many of them. She says she has never been jaundiced, but says that the stools have been light in color. On her arrival at the hospital she complained of a great deal of soreness in the right side of the abdomen. She had no fever or leukocytosis. She was apparently quite tender over the gall-bladder. She had a large nodular goitre more marked on the right side, but no evidence of Graves' disease. We excluded any kidney lesion and I was prepared to find gall-stones. I opened the abdomen through the right rectus and found the gall-bladder, ducts, stomach, and duodenum perfectly normal. The right kidney was free from adhesions and nothing abnormal could be felt about it. As the patient had said in the beginning her pain started under the left costal border and later became fixed on the right side, I examined the left kidney which was also normal. I had no difficulty in bringing the appendix into the wound and removed it, ligating, cauterizing and burying the stump. There was nothing in the appendix that I felt could account for the patient's severe attacks of pain. I cannot explain this case unless it was one of appendicitis and the appendix had entirely recovered. There was some thickening and congestion of the mucous coat, but I thought this was probably due to my manipulation.

6-10-'13. Patient made a good recovery, but I have been unable to get a reply to my letters of inquiry regarding her present condition.

Pain in the left side in gall-bladder cases, as suggested by Riesman, is probably due to adhesions between the bile passages and the stomach. In this case I found nothing else.

I realize that stones may be in a gall-bladder and palpation not show them, but if the gall-bladder is emptied by pressure then they can be felt. If the gall-bladder cannot be readily emptied then it should be opened, if the symptoms point clearly to gall-bladder disease.

Case V. Mrs. C. Pennsylvania Hospital. Cholecystitis. Chronic Appendicitis. Cholecystostomy. Appendectomy. 4-15-'12.

The patient's physician telephoned me that she was suffering from a severe attack of gall-stone colic which was not relieved by large doses of morphia. She was brought to the hospital twenty-four hours before operation. She had a previous attack of similar character a year or two ago. The present attack had come on suddenly with severe pain in the right upper abdomen, which radiated across to the left side but did not go to the back or shoulder. She vomited practically everything she had taken. The attack lasted several days. There were no urinary symptoms. She was not jaundiced, but said that she had had jaundice after the first attack. On admission to the hospital the pain had greatly subsided, but there was still marked tenderness over the gall-bladder region with some rigidity. Her urine was normal and her leukocytes 11,000. There seemed no doubt of the diagnosis. I opened the abdomen through the right rectus and found a long tense gall-bladder with extensive old adhesions about its lower portion and the cystic duct. The stomach and duodenum were normal, and I could feel no stones in the common duct nor in the gall-bladder. Before opening the gall-bladder I determined to examine the appendix which I found very long and densely adherent, its tip was attached by a firm adhesion to the right broad ligament. I removed the appendix with much difficulty, ligating, cauterizing and burying the stump. I then introduced a trocar into the gall-bladder, but the bile was so thick that it would not flow: on opening it I found that it contained thick black bile but no pus and no stones. The mucous membrane was acutely inflamed. A tube was inserted and the gall-bladder drained.

6-10-'13. The patient made a good recovery.

The attacks in this case I believe were undoubtedly due to the passage of plugs of mucus, or sloughs of mucous membrane.

These cases show very conclusively to my mind that infections of the gall-passages not only can but often do produce symptoms which are the counterpart of those accompanying the passage of a stone, and a practical lesson from these cases is that we should understand and make the patient or his family understand this, and that consequently

the failure to find a stone is no indication that the operation was unnecessary. We do not expect to find, as was at one time thought necessary, a concretion in every case of appendicitis. Furthermore, the gall-bladder like the appendix, may show few evidences in its interior of the fight it may have made against infection. Like the appendix after an acute attack of inflammation, the mucous membrane of the gall-bladder may appear normal, but the presence of adhesions to the neighboring structures is our proof that the diagnosis was correct and the operation indicated. We may not have arrived at the height of the conflagration, but we have come in time to remove the débris, put out the smoldering timbers, cleanse the site, and repair the neighboring structures.

Case VI. L. B. 46 Yrs. Pennsylvania Hospital. Cholangitis. Cholecystitis. Cholecystostomy. 8-25-'04.

I saw this patient first with Dr. Scott Law about the first of August. He was then suffering from a typical attack of hepatic colic. When I saw him the pain was controlled but there was a marked tenderness over the gall-bladder. The patient had had another attack about a year previous which the doctor diagnosed appendicitis. Frequent attacks of epigastric pain with indigestion had occurred. After I saw him he had two chills and became quite jaundiced. His temperature during this period was quite high, but gradually came down to normal and his jaundice subsided. Operation was advised, but as the doctor was going away, we thought we would wait until his return. However, the patient on the 17th developed another attack of hepatic colic and was admitted to the Pennsylvania Hospital on the 18th. This attack was not so severe as the previous one and the patient rapidly recovered from the pain. After the disappearance of the pain he again had two chills and his temperature remained high, about 103; jaundice was very marked. He did not vomit in this attack as he did in the previous ones. The fever gradually disappeared and the jaundice became less marked. At the time of operation there was no tenderness over the gall-bladder. His coagu-

lation was five minutes. I expected to find a stone in the common duct as I believed the patient to have had typical symptoms of this condition. When the abdomen was opened the gall-bladder was found very small and contracted, being about the size of a little finger; the stomach and omentum were very adherent to the gall-bladder and its ducts, and the separation of the adhesions produced considerable bleeding. The ducts were carefully palpated, but no stone could be felt. The gall-bladder was then opened, its walls found thickened and its mucous membrane at the fundus, black. A small quantity, probably $\frac{1}{2}$ teaspoonful of pure pus escaped, later considerable necrotic tissue. A careful exploration of the gall-bladder revealed no stone, however. I spent considerable time in examining the common duct. I exposed it to view at the point of its entrance into the duodenum and carefully palpated its remaining portion but no stone could be felt. The head of the pancreas seemed normal, but there were some enlarged retroperitoneal lymph glands. There was nothing to be felt in the neighborhood of the ampulla of Vater. I was very much disappointed not to find a stone in the duct and yet I felt there was enough in the adhesions and the condition of the gall-bladder to account for the symptoms. The upper gangrenous portion of the gall-bladder was removed, a rubber tube attached by a catgut suture to the remaining portion, and a gauge drain introduced well down below the point of attachment of the tube. The patient did not take his anaesthetic well and was considerably shocked.

6-10-'13. It has been nine years since the operation and this patient has had no other attacks.

A cholangitis can produce symptoms exactly like those which characterize a stone in the common duct.

Case VII. Doctor L. 34 Yrs. Pennsylvania Hospital. Duodenal Ulcer. Gastroenterostomy. 3-13-'13.

There is no hereditary history. During the summer of 1900, when a student at the Jefferson Medical College he had a great deal of stomach trouble and had a severe attack of colic; was admitted to the Jefferson Hospital and was attended by Doctors Keen and J. C. Wilson. A diagnosis of

gall-stone colic was made and he was in the hospital eleven days; no jaundice followed the attack and he gradually recovered. Again in 1902 he had a similar attack of pain, accompanied by vomiting, and was laid up for about the same length of time. Up to last June his health has varied. In 1907 he had pneumonia and developed an interlobular abscess which, he says, drained through rupture into a bronchus. On the 9th of January, he was again seized with sudden severe pain while visiting a patient, he vomited, was covered with cold sweat, was not relieved by two hypodermics and had to be given chloroform; the nausea kept up all the next day. The patient's weight has been about the same for the past few years. He says that he suffers more or less from gas after eating and that he is apt to have some pain, three or four hours after eating which is relieved by the taking of food: this, he says, may be all imagination. He has seen a number of physicians and at present Doctor Stengel has been going over him carefully. I found some gall-bladder tenderness and I believed that in view of the severe attacks of colic and the early diagnosis of gall-stones, that this was the correct diagnosis. Doctor Pfahler has made some excellent plates and his interpretation of them was that there were numerous adhesions about the pylorus which was held in a higher position than normal. Doctor Stengel inclined to the view that the patient had an ulcer. Under m. c. e. e. anesthesia I opened the abdomen through the upper right rectus and found extensive adhesions between the pylorus, gall-bladder and liver; some of these adhesions extended over the upper surface of the liver. No stones could be felt in the gall-bladder or ducts. There was a large irregular ulceration extending above the pylorus into the stomach and below into the duodenum, but making only a moderate constriction of the pylorus. The duodenal wall was indurated and contained a quantity of scar tissue. Undoubtedly the severe attacks of pain this patient has suffered were due to a localized peritonitis. There was no thinning of the ulcer at any place at this time. I did a posterior gastroenterostomy and infolded the pylorus with two rows of sutures; I then removed the appendix, ligating, cauterizing and inverting the stump. The appendix was practically normal, but the patient was very anxious to have it removed.

3-18-'12. The patient is quite comfortable and making an excellent recovery; he vomited much more than is usual after gastroenterostomy, but the material vomited was only water and albumen water which he had taken. The vomiting was relieved by putting him in a sitting position.

6-7-'13. Patient is well and attending to his practice.

Threatened perforation giving rise to localized peritonitis, as shown in this case, can certainly simulate gall-stone colic.

Case VIII. M. C. Jefferson Hospital. Cholecystitis. Duodenal Ulcer (?) Cholecystostomy. 3-11-'12.

This man was admitted to the hospital three or four days ago in a severe attack of pain which was localized over the gall-bladder region, extended across the abdomen and up to the right shoulder blade; he had a leukocytosis of about 18,000 and marked tenderness over the gall-bladder. I saw him the next day and there seemed to be no question in regard to the diagnosis. He had no urinary symptoms and I thought he had had gall-stone colic. There was still a good deal of tenderness and a slight rise in temperature. I thought it was better to wait until the acute symptoms subsided, and therefore kept an ice-bag over the gall-bladder region. The patient had vomited several times during his acute attack. He said he had had a similar attack last July though it was not so severe and he thought it was indigestion. Two days before I operated upon him he says that his urine was very highly colored and he thought that it contained blood; microscopic examination, however, showed no blood and the x-ray plate showed no stone. I opened the abdomen through the upper right rectus and found extensive adhesions between the duodenum, omentum, gall-bladder and liver; when I had separated these, I found the gall-bladder very tense and its wall infiltrated and containing lymph where it had been adherent to the duodenum. At a corresponding point on the duodenum there was a quantity of lymph and a marked induration of its wall; this was about two inches below the pylorus. I was puzzled to know whether this was an ulcer or whether it was simply due to the adhesions between the bowel and the gall-bladder: it looked exactly as if the

duodenum had adhered to the gall-bladder and a stone had been trying to perforate. The indurated area was not round but rather oblong and yet on feeling its inner surface through the bowel wall I could detect a distinct depression, though the intestine was not thinned at this situation. The gall-bladder was punctured and contained a quantity of absolutely black, thick bile of the consistency of syrup. The interior of the gall-bladder was inflamed, but no stone could be palpated in it or the ducts. The gall-bladder was drained with a tube, and I then infolded the area in the duodenum by the passage of deep sutures about its circumference. I am still in doubt as to the condition of the duodenum. There is no question that the patient had a cholecystitis and in the bottom of the gall-bladder there appeared to be pus, and yet I believed that the condition in the duodenum was an ulcer: I cannot otherwise explain the localized induration in the bowel wall especially in the absence of gall-stones.

3-16-'12. The patient is making a very satisfactory convalescence and there has been a free drainage of bile.

6-10-'13. This patient has remained well since his operation.

Case IX. I. I. 40 Yrs. Jefferson Hospital. Gall-stones. Cholangitis, suppurative. Cholecystostomy. Chole-dochostomy. 10-10-'09.

This man was admitted to the hospital about 11 p. m.; he was sent in by his physician as a case of appendicitis demanding immediate operation. He had a slight rise in temperature; pulse 110; a leukocytosis of 14,000, and was suffering a great deal of pain. The lower portion of his abdomen was soft, but the upper portion was rigid, especially on the right side. He described the pain as passing directly around to the back, but said that it did not radiate to the shoulder. He had not had any previous attacks, but gave a history of indigestion; he said that the stools had been light in color, but never tarry; he was pale, but did not seem to be jaundiced. The pain had come on suddenly at 4 p. m. and had been persistent. From the history given me over the telephone I thought there could be little doubt that he had a perforation of the intestinal

tract. When I saw him he had been given, according to my orders in preparation for the operation, $\frac{1}{4}$ gr. of morphine and, therefore, there was little rigidity; the man still, however, seemed to be suffering. I opened the abdomen through the upper right rectus. There was no escape of gas, and the gall-bladder was covered by adhesions so that just its fundus protruded; the stomach was drawn into the wound, but no ulcer was found, I felt something, however, through the stomach wall which I thought at first was an ulcer; it was movable, and my next thought was that it was a portion of food; on examining it more closely, however, I found that it was a pedunculated growth attached at the lesser curvature, about two or three inches from the pylorus; I never felt anything like it before and could not understand it. Leaving it for the time being, I examined the appendix region and found nothing wrong; I then began separating the old adhesions around the gall-bladder; these were very dense and the separation done with difficulty; finally, I could feel two large rough stones, apparently in the common duct. The gall-bladder was small and contained neither stones nor bile, finally I got the common duct exposed and opened it; there were two or three stones that measured $\frac{3}{8}$ of an inch in diameter and many smaller ones; the duct was enormously dilated and easily admitted my forefinger. In passing my finger upward the hepatic duct was found packed with the same soft stones; the removal of these was very difficult and the operation occupied over an hour. The dilatation of the hepatic duct was sufficient also to admit my finger quite a distance. I was surprised that so very little bile escaped; there was, however, a quantity of mucus, some sloughing mucous membrane, and a quantity of thin pus. With this accumulation of pus in the hepatic duct I thought the patient's condition very serious. The duct and gall-bladder were drained. I thought it unwise to investigate the pedunculated tumor in the stomach.

10-11-'09. This morning I was rather surprised and greatly relieved to find the patient in excellent condition. There had been a free discharge of bile through the tube and there had been a little nausea.

10-12-'09. Although in good condition yesterday, the patient's circulation began to fail about midnight and he

died about 7:30 this morning. I was surprised that this patient improved so much after his operation as I thought it quite likely that he might not recover, but his death at this time was a great surprise. His stomach was opened, post-mortem, and a pedunculated growth, which apparently is a polyp, was removed.

This case shows that a diagnosis made over the telephone cannot always be relied upon, and that an infection of the bile passages can produce symptoms similar to those of a perforative peritonitis.

Case X. Mrs. B. 38 Yrs. Bryn Mawr Hospital. Perigastric Adhesion. Excision. 5-10-'10.

This patient is married and has two children. Since last December she has suffered from indigestion manifested by flatulency with pain in the right hypochondrium and referred to the angle of the right scapula. Her first attack lasted a week; in February she had another attack in which nausea and vomiting were added to the other symptoms, and she says that her skin became yellow after this attack. Tenderness in the gall-bladder region has been persistent since December and the patient has lost weight. Under m. c. e. e. anesthesia I opened the abdomen through the right rectus and found a normal gall-bladder which could be emptied by pressure; the ducts were normal and free of adhesions; I could feel no evidence of ulcer in the stomach; the pylorus was normal in size and was quite low, and there was a point of adhesion extending from it to the anterior abdominal wall. This looked more like an abnormal attachment of omentum than like an inflammatory adhesion; it was so dense, however, that I could not draw the pylorus out of the wound until it had been divided. I believe this was the cause of the patient's discomfort, especially when I could find no ulcer in the duodenum. I put two mattress sutures in the lesser omentum after the manner of Beyea in order to draw the pylorus away from its old point of adhesion.

6-13-'13. The doctor reports that the patient is entirely free from all her previous symptoms.

Case XI. Mrs. F. 54 Yrs. Pennsylvania Hospital. Chronic Cholecystitis. Gall-stones. Cholecystostomy. 1-17-'10.

This patient has been married for thirty-seven years, but has never had any children; she had one miscarriage shortly after her marriage. She has always been strong and healthy until about four years ago. Menopause occurred eight years ago. Both parents died of paralysis, mother's sister died of either tuberculosis or cancer at the age of fifty-five. For several years the patient has had peculiar attacks, which as far as I can make out were gastric disturbances. Since March she has had vomiting attacks and epigastric pain radiating over the whole abdomen; since the middle of November she has been in bed, and it is said that she has lost considerable weight. The doctor discovered a tender spot above, and to the left of the umbilicus. The patient complains particularly of giddiness, even when she is lying flat on her back. I saw her at her home about a week ago. Because of the loss of weight and the inability to take any solid food, it was thought that she probably had a cancer of the stomach; she certainly had no symptoms of pyloric obstruction and no constant pain after eating; she was not cachectic, and had fairly good color. She was moved to the hospital where I have studied her for several days. A gastric analysis shows nothing significant, and x-ray plates of the stomach, filled with bismuth, are negative. I made up my mind that the trouble was probably in the gall-bladder, and in the x-ray plates the gall-bladder cast a shadow. Today under m. c. e. e. anesthesia I opened the abdomen through the right rectus and found the stomach perfectly normal; the gall-bladder was tense, distended and could not be emptied; I could detect no stones in the ducts and could feel none in the gall-bladder; just above the gall-bladder in the liver was a hard nodule in which I thought I could detect fluctuation. There was no adhesion about the gall-bladder or ducts. The gall-bladder was opened and there escaped a large quantity of grumous thick bile containing fine granules. The mucous membrane was thickened, inflamed and rough; one very small gall-stone was removed. Attached to one part of the mucous membrane was a tiny

granular growth containing sand. Some of the contents of the gall-bladder and this mass were sent to the laboratory for examination. The gall-bladder was drained. I incised the nodule in the liver and evacuated about a teaspoonful of clear fluid.

2-2-'10. The wounds are nearly entirely healed. The patient is up, but she still has occasional eructations of food. She also continues to complain of a number of queer sensations.

9-29-'10. The patient came in to see me today and has improved so much that I would not have known her. Her present weight is one hundred and eighty-four pounds. Apparently she has made a complete recovery.

Case XII. Mrs. G. 62 Yrs. Bryn Mawr Hospital. Gall-stones. Cholecystostomy. Choledochotomy. 1-17-'10.

I saw this patient for the first time just before the operation. A diagnosis of cancer of the stomach had been made, based on a history of attacks of vomiting and a gastric analysis, which plainly indicated cancer. The history of gastric trouble extended over four or five years. The patient did not look cachetic; she had never vomited blood; had never had tarry stools; an x-ray plate had been made while the stomach was filled with bismuth, and it was supposed to indicate an irregularity in the outline about the middle. I concurred in the diagnosis, but, because of some rigidity over the gall-bladder, the fact that the gastric disturbance had occurred in attacks, and because of the long duration of the case, said that I would not be surprised if we found gall-stones. On operating I opened the abdomen to the right of the middle line above the umbilicus. The stomach was normal excepting for one or two little enlarged glands in its serous coat; one of these I removed for examination. Palpation of the gall-bladder showed it to contain a number of large stones. The gall-bladder was entirely covered by an adherent colon, this was separated and the gall-bladder opened; there escaped a quantity of light yellow material which looked like fecal matter, then a large black stone with no facets. This was followed by a mass of tissue that looked like a "hair-ball"; on withdrawing this I found it to be the entire

mucous lining of the gall-bladder; this was covered with small black granules; when it had been removed, the gall-bladder was entirely emptied, but I could feel beyond several large stones, which it was impossible at the time to exactly locate; on further separation of the adhesions around the ducts, I discovered the common duct. When I opened the common duct a large mass of yellow material of the constituency of mud, was removed and another very large soft stone. Some bile also escaped. I was unable to pass my finger into the duct very easily; I passed a probe down into the duodenum and then sutured into the opening of the duct a large fish-tail drainage tube; another tube was fixed in the gall-bladder and the two brought out through another small incision made over the gall-bladder; a gauge drain was also carried down to the common duct and the median wound closed. The patient stood her operation very well. The material removed from the common duct was exactly like that removed from another common duct case operated upon at the Jefferson Hospital a few months ago.

2-2-'10. This patient is making an excellent convalescence and has had no untoward symptoms whatever.

Case XIII. Jefferson Hospital. Chronic Appendicitis. Chronic Cholecystitis. Appendectomy. Cholecystostomy. 4-17-'13.

I saw this man with Doctor McCrea in the medical ward some days ago and we thought the patient either had gastric ulcer, gastric cancer or gall-stones. There had been considerable loss of weight, vomiting, pain of a varying type sometimes referred to the back and shoulder, and jaundice. Doctor McCrea said the patient was slightly jaundiced on admission. The x-ray report was that the outline and function of the stomach were normal. The gastric analysis made on several occasions showed an absence of free hydrochloric acid, a low percent of combined acids and the presence of lactic acid. I opened the abdomen through the right rectus and found the stomach very large but otherwise normal. I was easily able to pass my finger through the pylorus. The pancreas was normal and I could find nothing wrong with the duodenum except some adhesions to the gall-bladder. The gall-bladder was large

and adherent at its lower portion and along the cystic duct to the duodenum. Before opening the gall-bladder, I examined the appendix and found it chronically inflamed and containing a large concretion near its extremity. It was removed, the stump being ligated, cauterized and buried. I then separated the adhesions between the gall-bladder and the duodenum and examined the common duct with a negative result. I then opened the gall-bladder and found the mucous membrane very red and angry looking, but no other abnormality. In view of the adhesions, the history, and the appearance of the gall-bladder, I drained it. A section of the gall-bladder was examined microscopically and said to be the seat of a chronic cholecystitis.

6-10-'13. This man is out, going about and seems perfectly well. No longer has any gastric symptoms.

The three cases (Nos. XI, XII and XIII) illustrate the difficulty sometimes encountered in differentiating gall-stones from cancer of the stomach.

Case XIV. Mrs. B. Jefferson Hospital. Acute Cholecystitis. Chronic Pancreatitis. Cholecystostomy. 2-17-'13.

This patient was admitted last evening to the hospital and I saw her upon arrival. The patient had had two attacks similar to the present one, the first occurring last summer; the present attack, which started yesterday morning, has been by far the most severe; it was sudden in onset and the pain was very acute and confined to the upper abdomen, especially on the right side. She also had pain in her right shoulder. Her pain was so severe that her physician, Dr. I. B. Roberts, was afraid that his previous diagnosis of gall-stone colic might be wrong and that the patient perhaps had a perforated ulcer. On admission to the hospital her temperature was normal; the pain had been relieved by a hypodermic of morphia, but she was still nauseated. Examination of the abdomen showed very localized tenderness and some rigidity immediately over the gall-bladder. I also thought I could detect a mass in this region. I felt confident that the patient was suffering from an attack of gall-stone colic and applied

an ice-bag thinking that she might wait until today for operation. Her leukocytes were 17,000, on admission, and this morning they had dropped to 13,000. The patient had a good night and feels quite comfortable today. She is decidedly jaundiced. Under anesthesia I was unable to feel any mass in the region of the gall-bladder, but with the spine resting on a sand-bag I could palpate the head of the pancreas distinctly; this caused me to be uncertain regarding the diagnosis. The abdomen was opened through the right rectus and immediately there escaped a quantity of bile-stained fluid and an elongated, greatly distended gall-bladder popped into the wound. The wall of the gall-bladder was edematous and infiltrated with bile; there was no point of threatened rupture, however, the bile simply seeping through the wall. No stones could be felt in the cystic or common ducts, both of which were free from adhesions. There was no fluid in the lesser peritoneal cavity. The pancreas, especially its head, was very much enlarged, but not hard enough to make me feel it was malignant nor soft enough to think that it was the seat of a hemorrhagic pancreatitis. I could feel no stone in the ampulla or in the pancreatic duct. The gall-bladder was drained and contained a large quantity of thick bile and apparently pus; a culture was taken. The mucous membrane of the gall-bladder was acutely inflamed and very red. A tube was inserted into the gall-bladder and a rubber covered drain into the right kidney pouch.

2-21-'13. The patient is making an excellent recovery, jaundice has disappeared and there has been a free flow of bile through the tube; she vomited occasionally a day or two after the operation, but all nausea has now disappeared.

This is the only case I have ever encountered where the distention of the gall-bladder was so great that the bile oozed through its walls, although similar cases have been reported.

Case XV. H. S. 55 Yrs. Jefferson Hospital. Chronic Pancreatitis. Cholecystostomy. Appendectomy. 3-1-'13.

This patient was sent in as a case of gall-stones or probably one of malignant growth in the upper abdomen.

For five years the patient has had indigestion, he never vomits, suffers from gas, and the last few months has had quite severe attacks of epigastric pain which radiated to the right side and up the back under the shoulder-blade. None of these attacks had been severe enough to require morphia, and in none of them has the patient vomited. He has lost considerable weight lately, and the skin of his face and the conjunctivae appear to be yellow. Examination of the abdomen shows marked tenderness in the gall-bladder region. Examination of the blood shows no anemia. The case seemed undoubtedly one of gall-stones, and today I opened the abdomen through the upper right rectus and found the gall-bladder and ducts free from adhesions and normal in every respect. The stomach and duodenum were perfectly normal. A few moderately enlarged glands could be felt in both the greater and lesser omenta. The pancreas was enlarged throughout and was quite hard. I had no difficulty in bringing the appendix up into the wound and removing it; ligating, cauterizing and burying the stump. It was slightly congested, but I did not think could account for the condition. There were no areas of fat necrosis encountered: the condition of the pancreas, however, made me feel that we were dealing with a case of pancreatitis.

6-6-'13. A note from his physician, Dr. Glasgow of Tyrone, Pa., states that he is perfectly well and has gained 28 pounds.

Case XVI. Doctor W. 45 Yrs. Pennsylvania Hospital. Acute Pancreatitis. Gall-stones. Cholecystostomy. 1-7-'11.

Doctor W. always appeared to be a very healthy man, although he did at times have trouble with his digestion. He was quite stout. Two days before I saw him, he was taken ill with severe pain in the epigastrium, the pain seemed to be diffused, and yesterday became apparently more localized in the right iliac region. He vomited in the beginning of his attack and has been nauseated since. When I saw him he had a temperature of 102°, a rapid pulse, slight distention of the abdomen, with tenderness and some rigidity in the lower right quadrant. He complained of some pain in the hypochondrium, but there was no tenderness or rigidity in the

upper half of the abdomen. His physician, Dr. Wm. E. Hughes, and I both thought he had acute appendicitis and he was moved to the Pennsylvania Hospital. On admission he had a leukocyte-count of 29,000. He had a slight bowel movement. He impressed one as being quite sick, and I expected to find a very bad appendix. I opened the abdomen through the sheath of the right rectus, and when the peritoneum was entered there escaped some straw-colored fluid. I was surprised on examining the appendix region, however, to feel no appendix. I finally separated and brought up what I thought was an appendix, but on examination, it seemed to be an epiploic appendage. The cecum was bound down, and I had considerable difficulty in bringing it up into the wound, but finally accomplished it and still could see nothing of the appendix. I thought that it might be placed between the layers of the meso-colon, but I could not feel it. At the end of the longitudinal band was a small short stump which looked like the stump of an amputated appendix. It may have been attached to the cecum, but I could demonstrate no opening. The opening was closed with two rows of sutures. The absence of any inflammatory condition in this neighborhood was very confusing, and I determined to explore the upper abdomen. On bringing the omentum out, I found it to be as thick as my hand and it contained several points of fat necrosis. On passing my hand into the gall-bladder region I found the omentum adherent to the gall-bladder, and the latter very tense. I at once made a diagnosis of acute pancreatitis and opened the upper abdomen through the upper right rectus. Because of the deep abdominal cavity I had considerable difficulty in obtaining a satisfactory access to the gall-bladder. The gall-bladder was emptied with a trocar of a quantity of thick dark bile. I then evacuated about one hundred stones of varying size. There were some adhesions about the duodenum, and I did not make a search of the common duct as the patient was in bad shape and the operation had already taken a long time. The gall-bladder was drained with a tube and two gauge drains introduced. The omentum, which was adherent to the gall-bladder, was filled with points of fat necrosis. The lesser peritoneum did not seem to be distended and there was no bloody fluid

in the cavity. I realized the serious condition of the patient, but hoped that with drainage he might recover.

1-10-'11. The patient died last night without showing any improvement after operation. The gall-bladder drained profusely, and the bowels moved several times without help, but the patient vomited nearly continuously up to the time of his death; his temperature gradually rose to 104°. I thought from the persistent vomiting and from the dark character of the vomit that probably the pancreatitis took on a hemorrhagic character. No post mortem examination was allowed.

Case XVII. Jefferson Hospital. Acute Hemorrhagic Pancreatitis. Gall-stones. Drainage. Cholecystostomy. 9-6-'10.

Excepting for the history of attacks of painful indigestion this patient has always been well and her appearance is very good. Three or four days ago she was seized with abdominal pain and was unable to have a bowel movement; vomiting occurred rather promptly and has kept up. She was brought down this morning from her home in the train. Her physician says that the vomiting became stercoraceous last night. I saw her four or five hours after admission and she then had been vomiting large quantities of bilious material; she had a temperature of 101° and a leukocytosis of 18,000; she said she had not even passed gas by the bowels for three or four days. There was some distention of the abdomen and some general tenderness which was most marked in the upper left quadrant; she presented no urinary symptoms. The patient certainly seemed to have obstruction of the intestinal tract and because of the tenderness and the leukocytosis, I judged it to be of an inflammatory origin and thought of a misplaced appendix or an inflamed Meckel's diverticulum. I opened the abdomen in the mid-line, just below the umbilicus and encountered some distended coils of small intestine. I could detect nothing abnormal in the pelvis or anywhere in the intestinal tract. In passing my hand to the upper part of the abdomen, I encountered what I believed to be a very much enlarged pancreas and on further exploration discovered that the gall-bladder contained stones.

Making a diagnosis of acute pancreatitis I made a second incision through the left rectus, above the umbilicus; on examining the pancreas from this position I had no doubt whatever of the diagnosis as it was very much enlarged and apparently symmetrically so. A small opening was made through the lesser omentum and a quantity of bloody exudate escaped. I then opened the gall-bladder and removed about twenty stones, a little larger than peas, and a great number of small ones. The gall-bladder contained very dark sticky bile; there was no normal bile whatever in the gall-bladder. I could feel no stone in the common duct. The gall-bladder was drained. I then increased the opening through the omentum and drained the lesser peritoneal cavity freely with gauge. From my manipulation of the pancreas there was considerable bleeding and I thought that I had done enough to relieve the congestion of the organ. The greater omentum showed extensive fat necrosis and a portion of it was removed for examination. The patient left the table in good condition, but later her pulse became very rapid and her temperature reached 103°. She did not vomit but her circulation became worse and she died at 2:30 this morning, ten hours and a half after operation. She had regained consciousness and was not restless and was fairly comfortable.

These two cases illustrate common errors of diagnosis especially the second, and I imagine that acute pancreatitis will continue to be mistaken for intestinal obstruction.

Case XVIII. Miss B. 38 Yrs. Pennsylvania Hospital. Cholecystitis. Gall-stones. Cholecystostomy. 12-9-'09.

This woman came into the hospital from Atlantic City at seven p. m., and I operated at ten p. m. She had been treated for four days before admission for intercostal neuralgia. She had been ill for a number of days and had one previous similar attack though not so severe; both attacks were accompanied by vomiting; she had never been jaundiced; no history of typhoid. The whole abdomen was tender, but there was marked tenderness and rigidity in the

upper right quadrant. It was thought that there was a mass in the gall-bladder region, but the rigidity was so marked as to render this uncertain. She had a temperature of 103°, respiration 44, and a leukocyte-count of 12,000. A diagnosis of cholecystitis was made. The abdomen was opened through the upper half of the right rectus. A quantity of lymph and exudate was found around the gall-bladder and ducts. The fundus of the gall-bladder was covered with lymph. The exudate was sponged away and the gall-bladder well isolated with packs; it was aspirated and then opened. When opened I was surprised to find that the muscular coat was gangrenous in spots but that the mucous membrane was not gangrenous. I removed about seventy-five small stones and a quantity of pus and sloughs of mucous membrane. I had no difficulty in palpating the cystic and common ducts, but could feel no stones. The gall-bladder was drained with a tube and a number of gauge drains was carried down to the ducts and around the gall-bladder.

12-10-'09. The patient is very much better. Her temperature is normal and she has no pain. The drainage is working well.

1-15-'10. This has been an extremely interesting case. Typhoid bacilli were found in the cultures taken from the gall-bladder and from the stones themselves. The wound has behaved very well, but the patient has run a continuous temperature from the fourth day after operation until about a week or ten days ago. She had several positive Widal reactions and undoubtedly had typhoid fever. She is at present convalescing and in good condition. Discharged 2-11-'10, cured.

I have seen another case in which I feel sure the patient has gall-stones and which has been treated as intercostal neuralgia and the acute exacerbations as acute indigestion.

The case also illustrates Sir Berkley Moynihan's recent remark that "Every gall-stone is a monument erected to the evil memory of the germ which lies buried within it."

The remarkable features of this case are that, according to the history, the patient had not had typhoid before operation and that she did have it afterwards.

Case XIX. Mrs. T. 28 Yrs. Germantown Hospital. Chronic Appendicitis. Misplaced Kidney. Appendectomy. 6-24-'12.

This patient has been married several years. She has three children, the youngest two years of age. Menstruation always regular, not very painful. Last August first had an attack of indigestion just after the menstrual period. This attack lasted two weeks. She had another in October and a bad one in December. Her physician, Dr. Gummey, discovered in December that the right kidney was quite movable, and thought that the patient's symptoms were probably caused by this. She has had a number of attacks since December. I first saw her in the office shortly after one of the attacks. She has no indigestion between the attacks which usually start with diarrhea and marked nausea. The nausea and vertigo keep up even when the patient is on her back. The pain is of a burning character located in the epigastrium and may later extend over the whole abdomen. The taking of food increases the pain. She has waked up occasionally with burning pain. No eructation of gas or food. Examination shows the patient to be very thin, the abdomen very soft, fundus easily palpated above the pubes. The only tender areas found at my first examination were over the gall-bladder and the appendix. The right kidney could easily be palpated but was not tender. I thought at first that the patient was suffering from chronic appendicitis, but on examining her again two weeks later after she had had an attack of pain, I found very marked tenderness over the gall-bladder. The patient also said that the pain passed directly across the abdomen and occasionally went to the right shoulder. The kidney was not tender on palpation and there was no appendiceal tenderness. When the patient was standing she located the pain and tenderness directly under the costal border, and there seemed to be a mass in this region which she herself had discovered. After this second examination, I was inclined to believe that this patient must have gall-stones and thought her gastric symptoms were due to this condition rather than to her appendix. Today under m. c. e. e. anesthesia I opened the abdomen through the outer portion of the right rectus a little above the umbilical line. I found the gall-bladder and ducts normal in

every respect. The right kidney had a range of motion of about two inches but a lower pole projected prominently forward. I was able with little difficulty to bring the appendix and the cecum into the wound. The latter did not look very bad, but seemed to be constricted about its center. It was removed; the stump ligated, cauterized and buried. Doctor G. opened the appendix at once and remarked that he thought there was quite enough in it to account for all the patient's symptoms, as there was a point of constriction with considerable thickening and congestion of the mucous membrane beyond it. I confess that in this case I was surprised not to find some trouble in the gall-bladder, and believe now that although the kidney was not tender when the patient was in a recumbent position that it was the lower pole of this organ which could be felt and was tender when the patient was standing.

7-12-'12. The wound is entirely healed and the patient is in good condition.

7-12-'12. The patient has made a prompt recovery and has gone home in good condition.

9-3-'12. In my office today and says she feels much better. Some soreness when jolted. Looks very much better.

This case shows how one who thinks he knows something about abdominal examination can be misled, and how the surgeon must sometimes doff his hat to the medical man.

Case XX. Mrs. H. Pennsylvania Hospital. Cholecystitis. Gall-stones. Cholecystostomy. 9-6-'10.

This patient was brought in from Bristol in an automobile last night. She was an extremely fat woman and had an enormous abdomen; she had been sick for a number of days with severe abdominal pain; her temperature on admission was 101° and her leukocytes 11,200; there was marked rigidity and tenderness in the upper right quadrant of the abdomen and apparently a distinct mass in that region. Her doctor said that he had never seen her in a typical attack of gall-stone colic, but she had had attacks which he thought were angina pectoris. The patient was much more comfortable this morning and the mass seemed smaller.

I opened the abdomen through the right rectus and came down at once on the gall-bladder covered with thickened and adherent omentum. The rest of the abdomen was protected by gauze and the adherent omentum separated from the gall-bladder. There was considerable lymph over the omentum but no free fluid. The gall-bladder was tense; it was punctured and a quantity of thick yellow pus evacuated. It was then opened and I removed two large stones, one firmly wedged in the cystic duct. I did not examine the common duct and I did not think it was wise in the presence of this infection to do so, especially as the patient presented no common duct symptoms. The mucous membrane of the gall-bladder was apparently necrotic throughout and portions of it could be easily removed. A large tube was inserted into the gall-bladder and a rubber-covered gauge drain placed outside of it.

6-10-'13. Patient made a prompt recovery.

This case shows that gall-stones can produce symptoms which may be mistaken for angina pectoris and every physician and every surgeon should read the interesting papers by Riesman of Philadelphia (J. Am. Med. As. May 11-'07 and Am. Jour. Med. Sci. Nov. '11) and Babcock of Chicago (Trans. Asso. Amer. Phys. XXIV, 43) on the relation between gall-stones and heart murmurs.

Case XXI. Mrs. D. Woman's Hospital. Gall-stones. Cholecystectomy. 10-7-'12.

The patient is a large woman, has had nine children, eight living; she has never had any illness and the family history is excellent. Last February she was seized in the night with an attack of abdominal pain for which two hypodermics of morphia were given. Since then she has had repeated attacks, the longest interval being eight weeks. The attack previous to the last one was the worst she has had. It was followed by jaundice. She also had fever in this attack. She always vomits followed by some relief. The patient is rather stout, but a healthy looking woman; there is no jaundice. Examination shows marked tenderness in the gall-bladder region and apparently a distended gall-bladder. She was sent to the Woman's Hospital and on the day of admission

had 19,000 leukocytes, but a normal temperature. She was having considerable pain on her arrival in Philadelphia, but this subsided entirely under rest and an ice-bag. I opened the abdomen through the right rectus and found a moderately distended gall-bladder, long and bent upon itself at the extremity like an interrogation point. There were adhesions about the fundus, but none about the ducts. The lymphatics were enlarged, but no stones could be felt in the ducts or gall-bladder. The stomach and duodenum were normal. The gall-bladder contained considerable bile having in it numerous small yellow granules and apparently pus and mucus. The interior of the gall-bladder was covered with these yellow granules presenting a typical strawberry appearance. A large number of these small stones were enmeshed in mucus. As I feared a return of the trouble if I simply drained, I determined to do a cholecystectomy. The gall-bladder was removed and a small rubber drainage tube sutured in the cystic duct as I thought drainage was indicated. I was able to cover the raw surface on the under surface of the liver by approximating two flaps of the serous coat of the gall-bladder. A small rubber drain was also fixed to the cystic duct and the wound closed.

10-9-'12. The patient has vomited but once since the operation and is in good condition.

10-24-'12. Has been up for several days; wound practically healed; no discharge of bile at any time; in good shape and goes home in a day or two.

This case is included in this list only in order to illustrate the "strawberry gall-bladder."

(All of these patients, with one exception, were anesthetized with chlorid of ethyl followed by ether and preceded one half hour by a hypodermic of morphia and atropine.)

Our failures to diagnosticate properly the conditions we treat are half the time due not to the fact that we do not know the differential diagnosis, but because we are struck with some prominent feature of the given case, jump to a conclusion and never consider the other possibilities. The making of a "snap diagnosis" has been a stumbling block

long enough and often enough in the experience of us all. A little more time given to the other possibilities will often change the apparently brilliant "snap diagnosis" into a different and saner one and sometimes save the operator much chagrin. The mistakes made honestly and conscientiously we can forgive, but those attributable to careless methods of examination and to over haste to operate should worry us always. How should a surgeon feel who, without examining the chest, opens an abdomen for a supposed perforation of the gastrointestinal tract, finds nothing and sees his patient die in a few days from pneumonia; or the internist who treats a child for rheumatism and then sees repeated operations for or death from osteomyelitis.

We need always to test our diagnoses and consider all possibilities. If we do this and make errors they cannot be counted against us, and if we do it our mistakes will be fewer.

As was said to me recently by a medical man "abdominal diagnosis before the days of abdominal surgery was easy and few mistakes were made; if the patient recovered of course we were right and if he died we too were right." The old Spanish proverb, "The earth hides as it takes, the doctor's mistakes," is no longer true. Now our mistakes are more frequent because the abdomen is opened and the true condition found.

We have learned much in twenty years, but more is to be learned and I believe a rehearsal of our errors in diagnosis will help us as much as anything. A review of my own mistakes I think will help me and I hope they may be of some help to you.

I once sat at the feet of a good and great man who prayed a prayer which every medical man should pray, "O Lord, make us dissatisfied with ourselves."

DISCUSSION OF ARTICLES XXIII AND XXIV.

DR. G. G. SEARS, Boston: After listening to the papers of our distinguished visitors one certainly has less excuse for those sins of omission and commission in diagnosis of which he has been too frequently guilty. I shall occupy your time only to emphasize a point which was introduced by Dr. Gibbon but which he failed to elaborate owing to lack of time. I refer to the occurrence of cardiac complications in connection with gall-bladder disease. Their development introduces an entirely new chain of symptoms whose urgency may dominate the picture and distract the attention from the underlying cause. They appear to arise chiefly in two ways, either as the result of toxic absorption resulting, directly or indirectly, from the inflamed gall-bladder, or as a reflex phenomenon. Very little attention has been given to the subject in the text books and one finds only a rare article in the periodical literature regarding it. It required a particularly striking case to force my own attention to it, and as this exemplifies the two ways in which gall-bladder disease chiefly affects the heart and as Dr. Gibbon reported no illustrative cases, I will give a brief summary of its most important features.

The patient was a lady of 38 who had been suffering for months from slight dyspnea, a rapid pulse and occasional paroxysms of tachycardia. She also had attacks which were practically those of angina pectoris — intense pain over the precordia extending to the left shoulder — but not dependent on either exercise or excitement. She also presented a number of neurasthenic symptoms, notably flushing and a tendency to profuse perspiration. She had not yet reached the menopause. None of her complaints suggested abdominal disease, but such symptoms might have been discovered if a more careful history had been taken. Physical examination showed a somewhat fleshy individual with a normal temperature, a pulse which while under observation never went below 90 and was frequently well over 100. The only organ found definitely abnormal was an enlarged thyroid gland. In connection with this the eyes

were suggestively prominent. The question of diagnosis was carefully discussed with several other consultants, and we had about determined to consider it a case of Graves' disease associated with mis-called pseudo-angina when she had an attack of typical gall-stone colic. The gall bladder was opened, one or two large stones removed and an uneventful recovery followed. Her previous symptoms disappeared.

Some time after this I came across a paper by Dr. Robert Babcock of Chicago in which he reported 13 cases in which cardiac symptoms and gall-bladder disease were associated. His classification of these cases is so good that I will quote him. He divides them into four groups, (1) those with pronounced cardiac incompetence with dilatation, arrhythmia, feeble heart action and murmurs.

(2) Those with attacks of pain that had been called angina with evidence of myocardial inadequacy, often with dyspnea from slight dilatation of the heart.

(3) Cases with prolonged intractable intermittency of the pulse, but without dyspnea or other cardiac signs.

(4) Cases with valvular disease, whose cardiac competency was destroyed owing to attacks of colic or distressing symptoms due to the gall-bladder.

It is of course to be remembered that cardiac failure may occur without disease of the gall-bladder, and when the two are associated it is possible to overestimate the importance of the latter as a factor in the downward progress of the case. The point which I have wished to emphasize is this, that in any case presenting cardiac symptoms, especially those of an anginal character, when the cause is obscure, it is wise to go minutely into the history and to direct one's physical examination with the special object of discovering if gall-bladder disease is not the underlying cause.

DR. BOTTOMLEY: I am now old enough in surgery to be willing to learn and to be taught. For that reason I came here today unprepared, without notes and with an open mind ready to receive impressions from two papers by honest men.

A medical meeting fails of its object unless those who attend it get something from it and go away either with

something in their minds that they did not have before or with something that they had before much better defined. From this meeting, it seems to me, there are two lessons to be drawn which, perhaps, may be expressed as follows:

First, it is evident from both papers that the difficulties of diagnosis of diseases of the right upper quadrant of the abdomen are very numerous and that in a certain proportion of cases, which grows less as we learn better to use means of diagnosis, an exact diagnosis is impossible. As a corollary to this, it is plain that a certain number of cases require an exploratory laparotomy as a means of diagnosis.

If I may digress a moment, let me call attention to the importance of a careful history as an aid to diagnosis. I have always thought that one of the most important things in a house officer's hospital training is his opportunity of acquiring the ability to take a good clinical history. On the surgical side of a hospital this opportunity is unusually great, for very frequently he may check up his clinical history by the facts of living pathology shown on the operating table. House officers are usually not taught to take good histories. I believe that more attention should be paid to this in hospitals.

Early diagnosis is extremely important in the treatment of diseases of the biliary tract. The dangers from surgical treatment lie not so much in the disease itself as in the sequelæ and in the complications. The simple cases do not go wrong. It is the neglected, long-standing cases of biliary disease which, when submitted to surgery, give the high mortality rate of from six to ten per cent instead of the less than one per cent mortality rate of the uncomplicated cases.

The second and equally important lesson to be drawn from these papers is that these diseases of the biliary tract are neither wholly medical nor wholly surgical. These cases fall within the province of the internist both ante- and post-operatively. Such cases as are not emergencies should have medical treatment before operation. Certainly, all cases should have medical treatment following operation. Some of the bad results of surgery come from our failure to recognize the fact that surgery alone will often not cure these cases. Careful medical treatment after operation should always be instituted

DR. WILDER TILESTON, New Haven, Conn.: It is a great pleasure to be with you once more I am sure. In discussing these two very illuminating papers, I shall confine myself chiefly to diseases of the gall-bladder.

In the first place I should like to say that I agree emphatically with Dr. Gibbon in the frequency with which cases occur where the diagnosis of gall-stones is made, operation done, and no stones found, but only an infection of the gall-bladder. This is so common that I think that where the symptoms clearly point to trouble in the gall-bladder, the gall-bladder should be opened and drained even if no stones can be located. I think some of the cases Dr. Stockton mentioned in which nothing was found at operation excepting darkened and altered bile can be attributed to infection, rather than to metabolism.

In the diagnosis of gall-stones the most important point I think is a very careful history. That is the thing that is most apt to be neglected, and if I had my choice I would rather have a careful history than a physical examination and the laboratory findings. The history of these attacks is that of severe pain coming on spasmodically and without any relation to food. The pain in the right shoulder is also very important from the point of view of diagnosis, and it should be remembered that it may be only in the right shoulder and not in the gall-bladder region at all.

In the second place I would speak of tenderness over the gall-bladder upon a deep breath, present in most infective cases, but absent where the stones are lying quiescent in the gall-bladder.

Differential Diagnosis. — It should be borne in mind that in gall-stones the pain is frequently in the epigastrium. In the case of duodenal ulcer the history again is of more importance than physical findings or laboratory findings. There is a story of pain coming on in the well-known manner when the stomach becomes empty and this is extremely suggestive of duodenal ulcer. The presence of occult blood in the stools of course points toward ulcer rather than gall-stones, but blood may be absent at repeated examinations in the case of ulcer. In ulcer hyperacidity is more common than in gall-stones, but it is not constant. More important in my opinion in the presence

of ulcer is an increased amount of gastric contents after a test meal. In most cases of duodenal or gastric ulcer especially if near the pylorus the diagnosis may be made with great probability from the x-ray. The important points are: (1) a six-hour residue which is often found where no fasting contents can be found with the stomach tube; (2) the loss of outline of the pylorus in several successive plates; and (3) the absence or irregularity of the duodenal cap. In a great many cases of duodenal and pyloric ulcer, some one or more of these x-ray findings are present, and when present they are extremely reliable.

Adhesions from the gall-bladder to the stomach may cause dilatation of the stomach, but that is quite rare. In the case of gall-stones the calculi themselves are not as a rule to be shown by the x-ray. The x-ray findings in cholelithiasis are suggestive rather than diagnostic. If adhesions from the gall-bladder to the stomach or colon are present, then you may get signs of them in the x-ray and, if they show, they suggest the diagnosis of gall-stones. It is important to remember that adhesions very rarely give rise to dilatation of the stomach or a six-hour residue in the x-ray picture.

The differential diagnosis between gall-stones and chronic pancreatitis is often impossible. This is less important, however, as the treatment is the same for the two conditions.

Another disease that should always be borne in mind in making a diagnosis of gall-stones is pyelitis on the right side, and unless the urine is examined a serious mistake may be made. Pyelitis is a very common disease in women and in young children, and is very frequently not recognized on account of failure to examine the urine properly. A catheter specimen in the case of a woman is almost essential.

I want to touch on the frequency of syphilis as the cause of hepatic cirrhosis, and also the excellent results to be obtained from anti-syphilitic treatment. There is no doubt that a great many cases of cirrhosis are being allowed to die which might be saved by treatment with Salvarsan and mercury, and, in case you are unable to have a Wassermann reaction done, it is better to give the patient the benefit of the doubt and give anti-syphilitic treatment.

DR. DAVID CHEEVER, Boston: The impression which stands out most clearly in my mind in connection with the diagnosis of gall-stones is the relative uncertainty in the diagnosis, except in typical cases, and this feeling has been confirmed by the two splendid papers which we have just heard. In many cases, we can have little more than a shrewd suspicion, and the more cases I see the more distrustful I feel of any evidence, except that which is purely objective, in making the diagnosis. If one can feel the distended and tender gall-bladder, or if intermittent or persistent jaundice appears in connection with other cardinal symptoms, or if, as is occasionally the fact, shadows are revealed by a radiograph, the diagnosis of gall-stones or at least of gall-bladder disease may be almost certain. The dependence which Dr. Tileston places upon the history is not justified by my own experience, unless indeed he means to refer chiefly to those cases which have a history of characteristic radiating pain, occasional evidence of occlusion of the ducts, and secondary gastric symptoms. Of course, as in any other disease, a carefully analyzed history is very valuable, but, in my experience, the very frequent cases which present a rather vague history of discomfort in the right upper quadrant and epigastrium, with varying complaints of gastric dyspepsia are quite as apt upon exploration to prove to be caused by some other condition. I am in entire accord with the statement of the other speakers, that it is much more common to make a diagnosis of gall-stones and upon exploration find some other condition than it is to find gall-stones unexpectedly when interference was undertaken for some other supposed disease. The past has shown that it is unwise to prophesy anything but progress in the diagnosis of disease, but it seems to me that there is nothing at present in sight to indicate the probability of much advance in the diagnosis of gall-stones unless progress shall be made in the use of the x-ray. At present, a small minority of gall-stones are imperfectly shown, but variations in the quality of the tube used and other conditions not wholly understood, as I am informed, sometimes enable the roentgenologist to obtain better plates. The diagnosis of diseases of the other abdominal organs, except possibly the pancreas and the spleen, has made much greater strides in

recent years. The chemical examination of the contents of the alimentary tract, the direct inspection of parts of the tract, and the use of the x-ray after a bismuth meal or injection have greatly simplified diagnosis in this field, and the cystoscope with ureteral catheterization and pyelography in connection with the x-ray have made the lesions of the bladder, and, in many cases, of the kidney, almost an open book.

The important thing is for the internist, as well as the surgeon, to realize that, in many obscure cases, an exploratory incision is one of the justifiable diagnostic procedures instead of being solely reserved as a therapeutic measure only if the diagnosis has been made. When the abdomen has been opened for suspected gall-stones, and none can be demonstrated, I believe it is wiser in most cases to drain the gall-bladder, unless some other condition is found to account for the symptoms. Otherwise, a very small calculus or a slight degree of infection of the gall-bladder may be overlooked. This procedure adds only slightly to the duration of the convalescence, and, if there proves to be even a slight cholecystitis or cholangitis, the right treatment will have been carried out.

In connection with the simulation of gall-bladder disease by other conditions, I recall a woman with acute abdominal symptoms centering in the upper abdomen, presenting diffuse tenderness and pain, radiating toward the right scapula in characteristic fashion. Operation revealed a ruptured right extra-uterine pregnancy, with moderate hemorrhage, and a normal gall-bladder. Some of the extravasated blood had passed up from the pelvis into the sub-hepatic region, possibly thus giving rise to the symptoms.

DR. HOMER GAGE, Worcester: I am very glad of this opportunity to express my appreciation of these two papers which have certainly been very illuminating, and very valuable.

Dr. Bottomley has spoken of two lessons which he has derived from them, to which I would add a third—*viz.*, that if a man of Dr. Gibbon's experience and ability and conscientiousness in studying his cases, makes his mistakes, there is some excuse for our own—although they are none the less distressing and humiliating.

A fourth lesson, it seems to me, is that the opening of the abdomen for gall-stones should be confined to those who have had some opportunity for the observation and study of living pathology.

When experts find it so difficult, even with all possible precautions, to recognize the exact condition, either before or at the time of operation, it seems wrong to encourage the performance of such operations by men of insufficient experience.

I am glad of the opportunity to thank Drs. Stockton and Gibbon for their fine papers.

DR. J. B. BLAKE, Boston: There is one other lesson to be learned from these papers and that is the not infrequent occurrence of more than one lesion of several coincident conditions. It is extremely important and apt to be forgotten. We ought to be given a hint from the records of the pathologist. They make a series of diagnoses; and of course it is true that we in practice seldom get advanced surgical or medical disease without having more than one serious lesion present.

Dr. Stockton referred to late syphilis, but syphilis may also present the symptoms of acute gall-bladder disease. I saw a case admitted to the gynecological service; it was apparently cholecystitis and probably gall-stones; temperature, tenderness and white count all being present. At operation a perfectly normal gall-bladder was found, but there was a tumor just to the left of the gall-bladder region, which was hard, white, round, about the size of a golf ball, and disappeared under treatment; a section showed gumma.

I am inclined to think that syphilis with acute symptoms is not quite so uncommon as we previously thought. The necessity of early operations in acute lesions of the right upper quadrant cannot be overestimated, and I am going to repeat a point which I made yesterday — namely, that it is easy to get patients to come into the hospitals for appendicitis, but it is much more difficult to get them to come with gall-bladder disease, and practitioners ought to try to make them come early, no matter how difficult the task of education may be.

DR. J. H. CUNNINGHAM, Boston: It seems from what has been said that there is a rather definite percentage of error in the diagnosis of diseased conditions of the gall-bladder that direct attention to other structures in the right upper quadrant of the abdomen for the explanation of some of this error. The right kidney, I believe, if examined properly, will furnish evidence which will diminish this percentage of error somewhat. There are two diseases of the kidney simulating gall-bladder disease. One is acute and the other chronic. Acute hematogenous infection of the kidney, or septic infarcts, simulates acute gall-bladder disease. Such cases have been operated upon for gall-bladder disease and have died, and the right kidney found to be the site of an acute hematogenous infection. The chronic condition referred to in the right kidney is hydronephrosis. This sometimes closely resembles chronic gall-bladder disease. The diagnosis of hydronephrosis cannot always be made from the history, physical examination and urine analysis, and the only way by which a hydronephrosis may be differentiated from gall-bladder trouble in certain instances is by cystoscopy catheterizing the right ureter and injecting the kidney cavities with one of the fluids which cast a shadow with the Röntgen rays. By so learning the capacity of the kidney cavity and recording its appearance on an x-ray plate hydronephrosis, its character and its etiological factor, may be demonstrated.

So long as we all admit this error, I think we ought to think of acute hematogenous infection of the right kidney in questionable cases of acute gall-bladder disease and of hydronephrosis in the chronic cases where the symptoms do not seem to be absolutely those of gall-bladder trouble.

DR. RICHARD C. CABOT, Boston: As long as all the possible sources of error are being brought out by Dr. Cheever, since he even spoke of extra-uterine pregnancy, it seems to me that we ought to mention one other not uncommon mistake. I refer to the gastric crises of tabes. They are operated upon for gall-stones quite often. I have seen at the Massachusetts General Hospital several cases which had been operated on and I have seen other cases which came mighty near being operated.

We used to think that if a patient had good knee jerks and good pupils it was not tabes, but this is not always the case. You ought to tap the spinal cord. I have known instances where we got a positive Wassermann in the spinal cord though the blood Wassermann was negative and the pupils and knee jerks were normal.

The only other thing that I would like to say is to reinforce what was just said in relation to the operation being performed by the man that knows the most. I do not know of any disease in which, from my own experience, it makes so much difference who operates, as in gall-bladder disease.

DR. F. B. LUND, Boston: I am certainly very strongly of the opinion that the man who has had the most experience ought to operate on these cases. They are often extremely difficult. I have probably had as many mistakes as Dr. Gibbon has had in diagnosis. Gall-stones may occur without gall-stone colic, and the larger the stone is, the less apt we are to have the colic. Gall-stone colics are the kind of gall-stone cases that are mistaken for ulcer of the duodenum. I have had cases of this kind. Then, gall-stones are not infrequently mistaken for cancer. We have a case in the hospital now of a man sent in for gall-stones because of the acute pain and repeated digestive disturbance, in which a good man had made a diagnosis of gall-stones. A mass was felt and the patient was emaciated. The x-ray showed what was thought to be a cancer, and what we found was a chronic ulcer which had perforated, the pains of perforation being mistaken for gall-stone colic.

Regarding excision of the gall-bladder: if you find a single stone impacted in the cystic duct or if the gall-bladder is much thickened, from my experience it is usually wiser to take out the gall-bladder than simply to drain it. In a recent case, the wife of a physician, we were in doubt whether to drain or to excise the gall-bladder, but finally decided to excise it on account of the great thickness of its wall, which thickening was largely inflammatory. In the separation of the adhesions preliminary to excision of the gall-bladder, we cleared the cystic duct and found a very large stone impacted in it, that would have been overlooked

had we not decided to excise the gall-bladder, and it would undoubtedly have caused great suffering and necessitated a second operation.

Where we are dealing with stones in the common duct, the history is all important. If you have chills with intermittent slight jaundice; by all means explore the common duct. I do not believe in opening the common duct in all cases, but in making a very thorough examination before stating that stones are not there. It is very easy for a loose stone in the common duct to slip up and down in such a way as to escape the palpating finger; and in a recent case with a very fat woman, I made three distinct attempts to palpate a stone before finally doing so. I mean, of course, with the abdomen open at the operation. If I had been less persistent, we should not have cured our patient, as there were stones in the gall-bladder which might have accounted for some of her symptoms; but the symptoms of chills with recurrent attacks of slight jaundice which she presented, stones in the gall-bladder would not account for. By the way, in her case, there was at no time colicky pain: merely a "slight distress" she called it, in the epigastrium. This is another misleading symptom in regard to diagnosis.

In some of these cases, one has to make a snap diagnosis. Of course, if there is time, a more careful diagnosis should be made; but in urgent cases, one has at times to go ahead, and in some cases the snap diagnosis may be right. I have had the experience of making a snap diagnosis and afterwards having time to think the case over of deciding my snap diagnosis was wrong and making another diagnosis, and then, on operating, finding that the snap diagnosis was right. This does not mean that one should not take all possible care in diagnosis, but that in the careful afterthought on a case, one may, by giving consideration to less prominent symptoms, fail to accord due prominence to the one symptom which enabled the surgeon to make a correct diagnosis at first, so that a shrewd guess is sometimes as good as careful reasoning. We must never forget, however, that if we do make a mistake, our conscience is not clear unless we have employed every means to reach a correct diagnosis.

DR. GIBBON: There are a few more things to emphasize if I may be pardoned for speaking again.

First, about the history taking. House officers should be thoroughly trained in correct history taking. It is a thing that every practitioner in medicine should do. He may not be able to carry out stomach analyses, to make bacteriological examinations and to conduct a great many other investigations, but there is no question about it, that the history of these patients will do more than any other one thing to differentiate the lesions, and this is a thing which we can always do if we will only take the time. There is one common excuse for not doing it and that is the fact that one is so busy that he has not time. It pays to take the time and then when the thing is done, someone else will not be finding later that you have been treating him without the knowledge which a good history would have given.

Of course we will go on making mistakes. We always do. But this will help to eliminate them.

In regard to tabes, about a month ago I divided the posterior nerve roots in a case of tabes with epigastric pain, in which a rather energetic but inexperienced surgeon had done a gastroenterostomy. The mistake was not in operating on this patient; but in doing the gastroenterostomy when no ulcer was found. Now this is a mistake which I think we are liable to make.

I do not believe that we ought to drain the gall-bladder in all cases in which the symptoms are present and we find nothing, but if we do find adhesions about the gall-bladder or any infection then we ought to drain it.

I was struck by one of the cases referred to in Dr. Stockton's paper where the ulcer was not felt. I believe that with experience we can feel most chronic ulcers of the duodenum and I do not think the chronic ulcer can easily escape detection.

It seems to me that acute erosion is not common, and if a patient has a chronic ulcer you ought to be able to find it.

I believe we can get over a good deal of our chagrin and difficulty if instead of making the diagnosis of gall-stones we say there is gall-bladder disease. When you operate for appendicitis you tell the patients they have an infection

of the appendix, and I believe that if we describe these gall-bladder diseases by saying that they have a gall-bladder infection, and possibly stones, we will not be so likely to destroy the confidence of our patients, because in a given case where you have told a patient that he has a stone, and then you do not produce a stone, he will never be satisfied.

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NOTICE TO FELLOWS OF THE SOCIETY.

1. The Society's Publications are issued as soon as practicable after the Annual Meeting. They are sent only to those who have paid their assessments, and to such Honorary and Retired Fellows as may apply for them.

2. The annual assessment should be paid in advance (*i.e.*, on January first) to the proper District Treasurer. Payments made previous to June first increase the annual dividends to the District Societies. In case of non-resident Fellows, payment should be made to the Treasurer of the Society, Dr. EDWARD M. BUCKINGHAM, 342 Marlborough Street, Boston. Checks should be made payable to the order of the Massachusetts Medical Society.

3. Fellows who, having paid their assessments, fail to receive the Publications, should notify at once the Librarian, Dr. EDWIN H. BRIGHAM, 8 The Fenway, Boston.

4. Fellows are requested to send prompt notice to the Librarian of changes of residence or office address, for the next Directory, which will be published as of January 1, 1914.

WALTER L. BURRAGE,
Secretary.

232 Newbury Street, Boston, Mass.

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

1. The first step is to identify the problem or question that needs to be addressed. This involves understanding the context and the specific requirements of the task.

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1. The first part of the document is a list of names and their corresponding addresses. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, New York, NY 10001; 456 Elm St, New York, NY 10002; and 789 Oak St, New York, NY 10003.

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Bulletin
of the
Massachusetts Medical Society

No. 1. August 1, 1913

PROCEEDINGS OF THE COUNCIL

October 2, 1912, to June 10, 1913

and

PROCEEDINGS OF THE SOCIETY

June 10 and 11, 1913



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Massachusetts Medical Society

PROCEEDINGS
of the
COUNCIL

October 2, 1912

February 5, 1913

June 10, 1913

Massachusetts Medical Society.

PROCEEDINGS OF THE COUNCIL.

OCTOBER 2, 1912.

A STATED MEETING of the Council of the Massachusetts Medical Society was held in the Boston Medical Library, October 2, 1912, at 12 o'clock noon, the President being in the chair and the following sixty-nine Councilors and at least four Presidents of District Societies present:

<i>Bristol North.</i>	G. W. Gay	<i>Suffolk.</i>
F. A. Hubbard	E. G. Hoitt	H. D. Arnold.
	A. A. Jackson	S. H. Ayer
<i>Essex North.</i>	J. W. Lawrence	J. B. Blake
R. V. Baketel	S. F. McKeen	E. M. Buckingham
I. J. Clarke	C. E. Mongan	W. L. Burrage
E. H. Noyes	L. M. Palmer	H. Cabot
F. B. Pierce	C. E. Prior	D. Cheever
V. A. Reed	E. H. Stevens	F. B. Harrington
F. W. Snow	J. O. Tilton	J. Homans
		W. L. Richardson
<i>Essex South.</i>	<i>Norfolk.</i>	J. D. K. Sabine
J. A. Bédard	A. N. Broughton	F. C. Shattuck
	G. G. Bulfinch	G. B. Shattuck
<i>Franklin.</i>	A. H. Davison	A. K. Stone
G. P. Twitchell	F. W. Goss	C. F. Withington
	T. E. Guild	
<i>Hampden.</i>	A. H. Hodgdon	<i>Worcester.</i>
T. S. Bacon	G. W. Kaan	W. P. Bowers
	B. Kent	O. H. Everett
<i>Middlesex East.</i>	W. C. Kite	R. W. Greene
E. D. Richmond	C. W. Macdonald	D. Harrower
	T. J. O'Brien	E. W. Norwood
<i>Middlesex South.</i>	J. W. Pratt	W. G. Reed
M. H. Bailey	E. T. Rollins	L. F. Woodward
F. J. Barnes	B. E. Sibley	S. B. Woodward
F. E. Bateman	F. W. Stetson	
J. E. Cleaves		<i>Worcester North.</i>
G. P. Cogswell	<i>Plymouth.</i>	C. E. Bigelow
C. H. Cook	G. Osgood	A. E. Mossman
		F. H. Thompson

The records of the last meeting were read and accepted.

The President made the following opening remarks:

Since this is the beginning of a new administration, it may be in order to speak of such matters brought to the attention of your President as may merit your consideration.

Living as we do in an age of progress and also, as we hope, in a process of evolution, new conditions may lead to changes in existing methods and even call for the creation of new plans to provide for the demands of the future.

By reason of the increase in our numbers with many consequent conflicting interests and opinions, and with the complicated relations of our various committees, together with the desirability of working in accord with the plans of the American Medical Association, there are opportunities for the exercise of great wisdom so that harmony may prevail and our Society perform its duty to all its members.

A careful consideration of the by-laws of our Society seems to indicate that a revision should be made, for certain of them are obsolete or defective; and since there are not many copies of the present edition left, and a new edition will have to be printed before very long, it would be wise to have this matter assigned to a committee. It may be advisable to consolidate some of the standing committees. The special rules of the Council and the standing votes and resolves should be incorporated so far as possible in the by-laws. A new by-law defining the status of papers read before the Society should be added. It has been suggested that the new code of ethics recently published by the American Medical Association that was submitted to the secretaries of the state societies and revised by competent authorities should be a part of this publication.

It is hoped that you will carefully study this proposition and appoint a committee which shall report recommendations at a future meeting.

To those of you who have served on committees having to spend considerable sums of money, some questions may have arisen as to our present way of dealing with our financial problems. The system now in operation in many instances permits committees to spend money without any official expression of opinion, as to method or amount, by the Council. The satisfactory result of this method so far is a testimonial to the executive and judicious quality of the work of these committees; but it is a method not usually adopted in organizations of this size, and as time goes on it must be a difficult task for any one committee to be able to determine what is fairly proportionate in the way of expenditure as related to the work of other committees.

The President submits that the only way, fair alike to the Society and to the committees, would be for each committee entrusted with the expenditure of funds above a certain fixed amount to submit its plans and estimates to the Committee on

Membership and Finance; then the Committee on Membership and Finance, after reviewing the whole situation, could recommend to the Council the appropriation of such amounts of money as might seem to be required by each committee. In other words, at the beginning of the year, a budget should be prepared and submitted to the Council. This would give each committee an opportunity to defend its claim for funds. Then after the Council had appropriated a definite sum, the committee would be relieved of the possibility of unjust criticism.

A continuance of the methods of the past must lead either to a reduction of the expenditures and reversions to the District Societies, or to an encroachment on the funds of the Society, unless some method can be devised to increase the income. This latter suggestion would not be likely to be received with enthusiasm if it involved a larger yearly assessment.

One plan adopted in recent years has not been on trial sufficiently long to warrant a study of its workings. Reference is made to the act for the defence of suits for malpractice. Every one recognizes the kindly and fraternal spirit which prompted this scheme, and the laudable desire to help carry the burdens of an unfortunate fellow; but there must rise in the minds of many the questions as to the justice and wisdom of using the resources of the Society for the benefit of the few. This matter in the opinion of some should be reconsidered and dealt with in a way to accomplish the greatest good.

Our relations with the American Medical Association are constantly developing important questions of policy, and now there are under consideration plans designed to solidify the component societies of the national body and make them reciprocally helpful. In its proper place in the programme there will be a letter read which calls for action.

It may be desirable both by reason of our relations to the American Medical Association as well as the common practice with most business concerns to change the financial year so that it will begin with the calendar year. This should be considered by the committee to be appointed to take under consideration the new by-laws.

Other questions of importance relate to our rules for admission to membership in the Society, so that we shall be in conformity with other similar bodies, to the end that reputable men coming to Massachusetts may join with us without being subjected to any unnecessary annoyance. This would be a comparatively easy thing to adjust if our state laws relating to licensure were better; but even with defective laws, certain changes can be made which will help to bring us into conformity with other states.

Many members have suggested a more complete directory; that is, with a local list added to the alphabetical list; but since there have been doubts expressed as to our ability to provide for larger outlays, it may be best to ask the Committee on Mem-

bership and Finance to confer with the Committee on Publications in order to determine whether there are sufficient funds for this purpose.

You may have noticed that the list of Honorary Fellows has been so reduced by deaths that we now have enrolled only two. If this custom is to be perpetuated, it will be necessary for you to bring forward names of such men as are entitled to this distinction.

The Chair would also like to suggest at this time that Councilors confer with the societies which they represent to ascertain the wishes of the members regarding arrangements for the Annual Meeting, and then forward them to the committee having this matter in charge.

The Committee on Publications through Dr. George B. Shattuck announced that the Shattuck Lecturer in 1914 will be Dr. Herbert C. Moffitt of San Francisco.

The Committee on Membership and Finance reported through Dr. Goss as follows:

The Committee on Membership and Finance would recommend that the petitions of the following to change their District Membership be granted:

Edward K. Sawyer, from Barnstable to Suffolk
Edmund W. Clap, from Middlesex South to Suffolk
Arthur T. Cabot, from Norfolk to Suffolk
David D. Scannell, from Norfolk to Suffolk
Fritz B. Talbot, from Norfolk to Suffolk
Washington B. Trull, from Norfolk to Suffolk

That the following be placed on the retired list:

Norman P. Quint, Medway

That the following be deprived of the privileges of membership for non-payment of dues:

Eben T. Aldrich, address unknown
William T. Bailey, address unknown
Benjamin W. Baker, Laconia, N. H.
Francis H. Beckett, Fall River
Alexis E. Bertrand, Lowell
James T. Buckley, Marlborough
John A. Carroll, Brookline
William H. Coon, Haverhill
John H. Costello, Dorchester
Henry L. Flynn, Roxbury
Charles B. Frothingham, Lynn
Raymond E. Gates, Roslindale
Edwin P. Gleason, Onset
Melville A. Harmon, Lynn

Harris B. Haskell, Wenatchee, Wash.
 Thomas F. Henry, Salem
 Lucius T. Ingham, Lee
 William J. Johnstone, Roxbury
 Fred P. Lowenstein, Westfield
 Eugene J. McCarthy, Malden
 Wilfrid A. Millet, Pittsfield
 John F. Moore, Worcester
 Eugene N. Mullins, Baldwinsville
 Louis P. O'Donnell, Melrose
 Charles C. Partridge, Belmont
 Chester A. Paull, Wales, Wis.
 Fred K. Porter, Southwick
 Solomon H. Rubin, Roxbury
 Harry A. Smith, West Roxbury
 Joseph A. Thissell, Tupper Lake, N. Y.
 William G. Turner, Fall River
 William W. Wentworth, Pittsfield
 Harvey H. Whitney, Ontario, Ore.
 William M. Wilkinson, Denver, Col.

Voted, To accept the report and adopt its recommendations.

The committees appointed at the last meeting to consider the petitions of P. O. Shea of Worcester, S. Delano of Boston, and T. F. Joyce of Lawrence, for reinstatement in the Society reported, favoring the reinstatement of these fellows, provided they pay the dues that they owed the Society at the time they were deprived of the privileges of fellowship plus the dues for the current year, within one month following October 2, 1912. (All were reinstated in due course.)

The committee appointed to consider the petition of F. S. Griffin reported, opposing his reinstatement.

Voted, To accept the reports and adopt their recommendations.

The petition of W. A. Parker of Medford for reinstatement was read by the Secretary and the following committee appointed to consider it: G. W. Nickerson; E. S. Jack; G. F. Dow.

The Secretary read the report of the delegation to the one-hundredth anniversary of the Rhode Island Medical Society; and the following were appointed delegates to the Annual Meetings of state medical societies as follows:

Vermont, C. L. French, Clinton
 N. P. Wood, Northfield
 New York, R. H. Seelye, Springfield
 J. B. Thomes, Pittsfield

The resignation of Dr. F. P. Denny as a member of the Committee to procure Scientific Papers was accepted, and Dr. F. T. Lord was appointed to fill the vacancy.

Dr. Walter Ela's resignation as a member of the Committee on Membership and Finance was accepted, and Dr. F. W. Taylor appointed in his place.

Dr. G. W. Gay was appointed a member of the Committee on State and National Legislation to fill the vacancy caused by the election of Dr. W. P. Bowers as President of the Society.

Dr. H. D. Arnold made the following report of the delegation to the House of Delegates of the American Medical Association at Atlantic City, June 3-6, 1912.

REPORT ON THE MEETING OF THE HOUSE OF DELEGATES OF THE
A. M. A. AT ATLANTIC CITY, JUNE 3 TO 6, 1912.

The Massachusetts Medical Society was represented by a full delegation, consisting of the following six delegates:

F. H. Thompson, Fitchburg
F. G. Wheatley, North Abington
Hugh Cabot, Boston
H. G. Stetson, Greenfield
H. W. Van Allen, Springfield
H. D. Arnold, Boston

The following Massachusetts men were delegates representing Sections of the A. M. A.:

R. F. O'Neil, Section on Genito-urinary Diseases
F. A. Washburn, Section on Hospitals

Thus our Society had eight members on the floor of the House of Delegates. Three served on Reference Committees, as follows:

Hugh Cabot, Sections and Section Work
H. D. Arnold, Medical Education
H. W. Van Allen, Credentials

Reapportionment

The regular apportionment of delegates once in three years was adopted at this session, on the basis of one delegate for every 700, or fraction thereof, in the membership of the constituent state associations on April 1, 1912. On this basis the Massachusetts Medical Society, with 3342 members, will be entitled to five delegates for the next three years, — a loss of one.

The following statistics are of interest.:

Number of physicians in Massachusetts	5648
Members of the Massachusetts Medical Society	3393
Members of A. M. A. in Massachusetts	1631
Non-members who subscribe for Journal	639

These figures are suggestive of possibilities of growth for our Society, since we include only 60 per cent of the physicians of the state, and a number of outsiders equal to about one-fifth of our membership are intelligent and enterprising enough to subscribe for the Journal independently.

Several matters of great importance, as affecting the relations of our Society to the A. M. A. and to sister state associations, were either adopted at this meeting of the House of Delegates or were pushed forward a step toward final decision.

Effect on Membership of Removal to Another State.

An amendment to the by-laws was adopted, in substance as follows. When a member of the A. M. A. removes to another state to practice medicine, he becomes eligible to membership in the component society of his new location "upon the presentation of a transfer card and an official statement that his dues have been paid in full in the society in which he holds membership." "He shall forfeit his membership in the American Medical Association one year after such change of location, unless he becomes a member of the constituent association of the state to which he has moved: Provided, however, that if the component society into whose territory such member has moved shall refuse him membership, the member shall be privileged to appeal to the Judicial Council of this association to determine whether or not he be guilty of any act that warrants the enforcement of the provisions of this section. Pending the decision of such appeal, he shall retain his membership in the American Medical Association through his original state association: and provided further, that the term 'practice of medicine' throughout these by-laws shall be held to mean the offering of service or counsel for the relief of those suffering from abnormal physical or mental conditions."

Uniform Regulation of Membership.

This matter has received the serious attention of the House of Delegates since a committee on this subject was appointed in 1908.

This committee recommended that all state associations be requested to make their fiscal year conform to the calendar year and to request the component county societies to adopt the same rule.

In 1910 the committee recommended that membership should be good for one year only, that the roll should be made out each year and include only those who have paid their dues on or before a certain date, thus doing away with "suspended" members and those "not in good standing."

The committee also recommended that a uniform system of records be devised.

These recommendations have been adopted.

At the last meeting, in 1912, these recommendations were reaffirmed. It was also recommended that the constituent state associations should hold charters from the American Medical Association, and that a uniform plan for the transfer of members from one component county society to another was necessary for the good of the organization. A plan for such transfers was worked out. It was also recommended that the county societies should hold their annual meetings in October and that the newly elected officers (except delegates) should assume office on January 1 following.

The report of the committee concludes as follows. "In view of the importance of the proper regulation of membership matters for the good of the Association, and of the widely different customs that have been followed heretofore in the various state associations, it seemed advisable to the committee that the entire question of membership, its method of regulation and its bearing on the work of the organization should be thoroughly discussed by the executive officers of the various constituent state associations. . . . A thorough understanding of existing conditions, and of the relations of the various parts of the Association to each other on the part of the executive officers of the state associations, is, in the opinion of the committee, of the utmost importance.

The committee, therefore, recommends that a meeting of the secretaries of the constituent state associations be called in Chicago some time during the fall of 1912, and that the Board of Trustees be requested to appropriate a sufficient amount of money to pay the travelling expenses of the state secretaries in attending this meeting, and that the recommendations of this committee as contained in this report be approved by the House of Delegates and that the committee be instructed to present these recommendations to the state secretaries for their approval and adoption."

These are matters in which the Massachusetts Medical Society is vitally interested. The American Medical Association has issued invitations for such a meeting of the secretaries of the state societies to be held in Chicago the latter part of this month. It seems desirable that our Society should be represented at this conference, which will undoubtedly have a great influence in shaping the final action of the Association.

Proposed Amendments to the Constitution and By-laws to Extend Membership.

A committee, which had been appointed to consider this matter, made its report. In general the plan recommended is that membership in the constituent state associations shall carry with it automatically membership in the A. M. A.

The members of the A. M. A. are then divided into four classes: members; fellows; associate fellows; and honorary fellows.

Membership carries simply the right to vote for Delegates.

If a member applies for fellowship and subscribes to the Journal, paying the annual dues for the current year, he shall be a fellow. In other words, a fellow will have the rights now held by members of the A. M. A. He will have the right to active participation in the scientific meetings of the association, will be eligible to a place on the programme, will be eligible to serve in the House of Delegates of the A. M. A. if he has been a fellow for the two preceding years, and he will receive the Journal.

Associate fellows and honorary fellows are to be the same as the present associate members and honorary members.

These proposed changes were referred to the Judicial Council with power to confer with constituent associations and to report to the House of Delegates. This subject will probably also be under discussion at the meeting of the Secretaries.

Principles of Ethics.

A revision of the Principles of Ethics, submitted by the Judicial Council, was adopted after slight modification. It was voted to send a copy to all members.

Medical Education.

The first classification of medical schools was made in 1907 after an inspection and marking of the schools on a civil-service basis, the different items being grouped under ten heads. Since then 56 schools have been closed, — 37 during the interim between the Council's first classification and the publication of its second classification in 1910, and 19 in the past two years.

The House of Delegates at its last meeting authorized the publication of the third classification. It also authorized a subdivision of the Class A schools into Class A and Class A plus. This latter class are the only ones now regarded as "acceptable." Schools in this class receive a rating of 70 per cent or above in each and all of the divisions of data.

"After January 1, 1914, all colleges to be included in Class A must require not less than one year of college credits in chemistry, biology, physics, and a modern language, or two or more years of work in a college of liberal arts, in addition to the accredited four-year high-school course."

Of the 56 schools that have been closed, 28 have merged with other schools and 28 have become extinct. Twenty-three of the 28 merged schools belonged to classes A and B, while 23 of the 28 extinct schools belonged to Class C. Thus the work has resulted in putting out of existence a considerable number of the weakest schools and the strengthening of the better schools by a combination of their resources.

The Council on Medical Education was authorized to initiate an investigation of the hospitals of the country as to the opportunities offered to internes. This is the first definite move toward the requirement of a fifth "hospital" year for the degree of M.D.

A new Section was created in Orthopedic Surgery.

Dr. John A. Witherspoon, of Nashville, Tennessee, was elected President for the ensuing year.

Dr. W. T. Councilman was reelected to the Board of Trustees, and Dr. W. B. Cannon was reelected to the Council on Health and Public Instruction.

The next meeting will be held in Minneapolis, June 17-20, 1913.

Respectfully submitted,

H. D. ARNOLD.

Voted, To accept the report. On the motion of Dr. G. W. Gay it was *Voted*, That the report be offered to the Boston Medical and Surgical Journal for publication.

A letter from the American Medical Association to the Secretary, inviting the Secretary to a meeting of all the secretaries of the constituent state associations to be held in Chicago on October 23 and 24, 1912, was read by the Secretary. Remarks on this invitation were made by Dr. Arnold, who introduced the following two motions:

Moved, That a committee be appointed to consider the relations of The Massachusetts Medical Society to the American Medical Association and to other state societies, and that it make a report to the Council at its annual meeting.

This committee shall consist of the following officers: the President, Vice-president, Secretary, and Treasurer, and the following to be chosen by the President:

One member of the Committee on Membership and Finance

Two Presidents of District Societies

Two Secretaries of District Societies

Two of the delegates to the American Medical Association who attended the last meeting of the House of Delegates

Moved, That the Council authorize the Secretary of The Massachusetts Medical Society, or some member of the above committee to be chosen by the President, to attend the proposed meeting of secretaries of the state societies at Chicago, and that the Society defray expenses other than those paid by the American Medical Association.

The motions were discussed by the following Councilors:

G. B. Shattuck, C. F. Withington, F. W. Goss, E. M. Buckingham, C. H. Cook, the Secretary, and H. D. Arnold. The motions being put were passed unanimously.

The President chose for this committee the following:

S. Crowell, from the Committee on Membership and Finance; A. R. Crandell, President of the Bristol North District Society; I. S. F. Dodd, President of the Berkshire District Society; J. F. Burnham, Secretary of the Essex North District Society; W. L. Bond, Secretary of the Middlesex South District Society; and H. D. Arnold and H. Cabot from the delegates to the last meeting of the House of Delegates of the American Medical Association; and he chose H. D. Arnold to represent the Society at Chicago, October 23 and 24.

Dr. G. B. Shattuck presented the following two motions, and they were passed unanimously:

Moved, That all papers presented at the two-day annual meetings of the Society shall be the property of the Society.

That no paper shall occupy more than twenty minutes in its delivery except the Annual Discourse and the Shattuck Lecture.

That all papers shall be typewritten and ready for publication, and accompanied by suitable material for illustrations, if any, at the time they are read to the Sections or to the Society. Within ten days after their presentation, they shall be handed to the Secretary or his representative, who will submit them to the Committee on Publications.

Moved, That no one discussion shall occupy more than five minutes except by unanimous consent of the meeting.

Those who take part in discussions shall correct and return promptly to the Secretary the transcribed stenographer's notes of their remarks for inclusion in the Medical Communications if deemed proper by the Committee on Publications.

Adjourned at 1.30 P.M.

WALTER L. BURRAGE,
Secretary.

FEBRUARY 5, 1913.

A STATED MEETING of the Council was held at the Boston Medical Library, February 5, 1913, at twelve o'clock noon, the President being in the chair, and six presidents of District Societies several chairmen of Standing Committees and the following seventy-two councilors representing sixteen districts being present:

<i>Barnstable.</i>	<i>Bristol North.</i>	<i>Bristol South.</i>
J. H. Higgins	F. A. Hubbard	W. A. Dolan
<i>Berkshire.</i>	S. D. Presbrey	J. H. Gifford
O. J. Brown		H. G. Wilbur

<i>Essex North.</i>	C. E. Mongan	J. B. Blake
E. H. Noyes	C. E. Prior	E. M. Buckingham
F. W. Snow	G. Ryder	W. L. Burrage
F. E. Sweetsir	E. H. Stevens	H. Cabot
		D. Cheever
<i>Essex South.</i>	<i>Norfolk.</i>	H. A. Christian
J. A. Bédard	A. N. Broughton	F. J. Cotton
N. P. Breed	G. G. Bulfinch	R. H. Fitz
	P. J. Fleming	W. H. Grainger
<i>Franklin.</i>	F. W. Goss	F. B. Harrington
G. P. Twitchell	T. E. Guild	W. L. Richardson
	G. W. Kaan	J. D. K. Sabine
<i>Hampden.</i>	B. Kent	G. G. Sears
S. A. Mahoney	W. C. Kite	G. B. Shattuck
	C. W. Macdonald	A. K. Stone
<i>Middlesex East.</i>	C. Malone	C. F. Withington
H. B. Jackson	R. M. Merrick	G. Wolcott
	T. J. O'Brien	
<i>Middlesex North.</i>	J. W. Pratt	<i>Worcester.</i>
R. J. Meigs	E. T. Rollins	W. P. Bowers
	A. M. Worthington	O. H. Everett
<i>Middlesex South.</i>	<i>Plymouth.</i>	H. Gage
F. E. Bateman	A. E. Paine	R. W. Greene
J. E. Cleaves	F. G. Wheatley	D. Harrower
G. P. Cogswell		E. B. Harvey
C. H. Cook	<i>Suffolk.</i>	S. B. Woodward
G. W. Gay	H. D. Arnold	
E. G. Hoitt	S. H. Ayer	<i>Worcester North.</i>
S. F. McKeen	F. G. Balch	F. H. Thompson

The records of the last meeting were read and accepted.

Dr. Homer Gage called attention to the desirability of revising the by-laws, a matter which had been advocated previously by the President at the October meeting and by the outgoing President at the annual meeting, last June. Dr. Gage moved, and it was

Voted, That a committee of five be appointed by the chair to revise the by-laws, and that the proposed revision be printed and distributed to every fellow with the call for the annual meeting, in May.

The President appointed the following committee:

H. Gage, Worcester
 J. A. Gage, Lowell
 J. W. Bartol, Boston
 H. Cabot, Boston
 W. L. Burrage, Boston

Upon nomination by the President, the following delegates were appointed:

To the American Medical Association for two years:

H. Cabot, Boston
 J. B. Blake, Boston, Alternate
 C. P. Hooker, Springfield
 H. E. Sears, Beverly, Alternate
 G. Osgood, Rockland, Alternate

To the annual meetings of state medical societies:

Maine; G. Z. Goodell, Salem
 H. P. Stevens, Cambridge
 New Hampshire; H. W. Manahan, Lawrence
 G. S. Allen, Lawrence
 Rhode Island; A. R. Crandell, Taunton
 E. Washburn, Taunton
 Connecticut; F. B. Sweet, Springfield
 G. H. Janes, Westfield

To conference on Medical Education and to Association of American Medical Colleges at Chicago:

H. C. Ernst, Jamaica Plain

To be a member of the National Legislative Conference of the American Medical Association at Chicago:

C. F. Withington, Boston

Upon nomination by the President, the following were appointed to audit the Treasurer's accounts:

C. J. White, Boston
 D. N. Blakely, Brookline

Dr. Goss for the Committee on Membership and Finance reported as follows:

The Committee on Membership and Finance respectfully reports and recommends,

That the petitions of the following to change their district membership be granted:

Arthur R. Kimpton from Middlesex South to Suffolk					
Henry D. Lloyd	"	"	"	"	"
H. Sterling Pomeroy	"	"	"	"	"
James S. Stone	"	"	"	"	"
Gerardo M. Balboni from Norfolk to Suffolk					
Joel E. Goldthwait	"	"	"	"	"
Annie L. Hamilton	"	"	"	"	"
George F. Harding	"	"	"	"	"
Alonzo G. Howard	"	"	"	"	"
Edward Reynolds	"	"	"	"	"

That the resignations of the following be accepted:

Thomas Howell, New York, N. Y.
Ernest T. F. Richards, St. Paul, Minn.

That the following be placed on the retired list:

James A. Dow, Belmont
Benjamin D. Gifford, Chatham
B. Joy Jeffries, Boston
Frederick W. Russell, Winchendon

That the following be deprived of the privileges of membership for non-payment of dues:

Aubrey J. Collins, Mattapan
Edward J. Cotter, Jamaica Plain
George R. Fessenden, Ashfield
Cornelius E. Geary, Fitchburg
Estella L. Mullin, San Diego, Cal.
Percy Musgrave, Washington, D. C.
Joseph H. Saunders, Brookline
Anna Topaz, Providence, R. I.

Voted, To accept the report and adopt its recommendations.

The secretary read the report of the committee appointed to consider the petition of W. A. Parker recommending that he be restored to the privileges of fellowship.

Voted, To accept the report and adopt its recommendations. (Dr. Parker became a fellow in due course.)

In the absence of the chairman, Dr. J. F. Burnham presented a revised list of medical schools and colleges for the purposes set forth in By-law 1, and the list was adopted unanimously.

The committee appointed to consider the relations of The Massachusetts Medical Society to the American Medical Association and other state medical societies reported through Dr. Arnold, who outlined his experiences at the meeting of secretaries of state medical societies at Chicago, last October, and sketched the resolutions which were passed at that time. He stated that his committee wished to make a preliminary report, and presented to the meeting the following four resolutions with explanation as to their purport:

1. *Moved*, That the fiscal year of the Society begin on the first day of January of each year on and after January 1, 1914, all resolutions or votes to the contrary being hereby annulled.

2. *Moved*, That the assessment for the period from April 15, 1913 through December 31, 1913, shall be \$4.00.

3. *Moved*, That after January 1, 1914, the first assessment paid by fellows who are admitted to the Society following the November examinations shall be considered as including the

annual assessment for the succeeding fiscal year. This privilege shall be extended to those fellows admitted as a result of the examinations in November 1913 on the payment of an assessment of \$5.00.

4. *Moved*, That it is the sense of the council that members in good standing of other state and territorial medical associations who apply for fellowship in the Massachusetts Medical Society shall be admitted to fellowship on the same basis as fellows of the Massachusetts Medical Society who have resigned and apply for readmission, provided that such members of other state and territorial medical associations meet the requirements of By-laws 1 and 2. Therefore it is directed that this provision be included in the draft of the next revision of the by-laws.

The motions being read and acted on severally were passed unanimously.

The secretary read a communication from the committee of the Society on Public Health, which was accepted.

On motion of Dr. R. I. Lee, it was

Voted, That the council indorses the four following propositions which were embodied in the said communications, namely:

1. That local health administration be placed as far as may be in the hands of a single official who shall hold office during his continued efficiency.

2. That said officials, wherever possible, be men trained for their special duties.

3. That in neighboring and sparsely settled communities a single health official be given authority over two or more towns or communities.

4. That communities be shown the advantages of such permanent trained health officials; that they be urged to obtain such officials; and that they be stimulated to support them loyally when they have obtained them.

Dr. A. N. Broughton, Chairman of the Committee of Arrangements, outlined in a general way the plans for the coming annual meeting; and Dr. Arnold, for the officers of the sections, reported along the same lines.

Dr. Broughton asked for an expression of opinion from the council whether the annual dinner should be given in the middle of the day or in the evening. The question was discussed at considerable length by the following men; H. C. Ernst, C. F. Withington, J. F. Burnham, J. B. Field, E. B. Harvey, G. B. Shattuck, and F. W. Goss, and the many advantages and disadvantages of a dinner at either time were set forth in detail; also the merits of a postal card vote and reference of the question to the district societies were discussed. Dr. Prior stated that he had complete confidence in the Committee of Arrangements, and that he thought there were no more complaints last year than in past years; and

that it was difficult to get an opinion by a postal card vote; therefore he

Moved, That the matter be indefinitely postponed; and it was so voted.

Dr. W. H. Merrill presented a communication from the Essex North District Medical Society as to the practical application of the Workmen's Compensation Act as it relates to the care of injured employees by hospitals and physicians.

Dr. Watts, President of the Norfolk District Society, discussed the communication, pointed out the present unsatisfactory situation, and presented the following motion:

Moved, That a committee of five members of the Council be appointed by the President to consider the workings of the "Workmen's Compensation Act," so called, as it affects the physicians of Massachusetts; to cooperate with the Committee on State and National Legislation; and to report at the annual meeting of this Council in June, the result of its findings, together with such recommendations as it may deem expedient.

Comments were made by Dr. Sweetsir, Dr. Malone, Dr. Field, and Dr. Cotton. A motion to amend Dr. Watts' motion by making the committee six instead of five members was lost; and the original motion was passed unanimously. The President appointed the following as this committee:

F. J. Cotton, Boston, *Chairman*
W. A. Dolan, Fall River
S. B. Woodward, Worcester
F. W. Snow, Newburyport
R. J. Meigs, Lowell

Adjourned at 1.45 P.M.

WALTER L. BURRAGE,
Secretary.

JUNE 10, 1913.

THE ANNUAL MEETING of the Council was held at the Copley-Plaza Hotel, Boston, June 10, 1913, at twelve o'clock noon, the President, Dr. W. P. Bowers, being in the chair and the following one hundred and twelve councilors present:

The initials M.N.C. following the name of a councilor indicate that he is a member of the Nominating Committee.

Barnstable.

J. H. Higgins, M.N.C.

Berkshire.

J. F. A. Adams
L. A. Jones, M.N.C.

Bristol North.

A. R. Crandell
F. A. Hubbard, M.N.C.

Bristol South.

W. A. Dolan

Bristol South (cont.)

J. H. Gifford
H. G. Wilbur, M.N.C.

Essex North.

J. E. Bryant
I. J. Clarke, M.N.C.
E. H. Noyes
F. B. Pierce
F. E. Sweetsir

Essex South.

H. D. Abbott
G. G. Bailey
J. A. Bédard
N. P. Breed
A. H. Martin
H. L. Paine
H. E. Sears, M.N.C.

Franklin.

G. P. Twitchell

Hampden.

T. S. Bacon
J. M. Birnie
C. P. Hooker, M.N.C.
J. C. Hubbard
C. F. Lynch
S. A. Mahoney

Hampshire.

A. G. Blodgett
M. W. Pearson, M.N.C.

Middlesex East

D. C. Dennett, M.N.C.
G. N. P. Mead
E. D. Richmond

Middlesex North

G. O. Lavalée
R. J. Meigs

Middlesex South

M. H. Bailey
H. T. Baldwin

F. J. Barnes
F. E. Bateman
J. E. Cleaves
C. H. Cook
G. W. Gay
E. G. Hoitt
A. A. Jackson
J. B. Lyons
S. F. McKeen
C. E. Mongan
L. M. Palmer
C. E. Prior
Godfrey Ryder
E. H. Stevens, M.N.C.
Julia Tolman

Norfolk.

A. N. Broughton
G. G. Bulfinch
Samuel Crowell, M.N.C.
A. H. Davison
F. P. Denny
E. W. Finn
P. J. Fleming
F. W. Goss
T. E. Guild
W. W. Harvey
A. H. Hodgdon
S. A. Houghton
G. W. Kaan
Bradford Kent
C. W. MacDonald
T. J. Murphy
A. R. Sawyer
A. E. Sherburne
B. E. Sibley
C. F. Stack

Norfolk South.

O. H. Howe
E. N. Mayberry, M.N.C.

Plymouth.

Gilman Osgood
A. E. Paine, M.N.C.
F. J. Ripley
F. G. Wheatley

Suffolk.

H. D. Arnold
 S. H. Ayer
 F. G. Balch
 J. W. Bartol
 J. B. Blake
 E. H. Bradford
 E. M. Buckingham
 W. L. Burrage
 Hugh Cabot
 G. A. Craigin
 W. H. Devine
 R. H. Fitz
 W. H. Grainger
 J. J. Minot
 W. L. Richardson
 J. D. K. Sabine
 G. G. Sears
 F. C. Shattuck, M.N.C.
 G. B. Shattuck

A. K. Stone
 C. F. Withington

Worcester.

W. P. Bowers
 C. A. Church
 W. J. Delahanty
 J. T. Duggan
 O. H. Everett
 Homer Gage
 R. W. Greene
 David Harrower, M.N.C.
 L. F. Woodward
 S. B. Woodward

Worcester North.

C. E. Bigelow
 A. E. Mossman
 E. A. Sawyer, M.N.C.
 J. W. Stimson

The records of the last meeting were read and accepted.

The names of the Nominating Committee were read by the Secretary and the committee retired.

The Treasurer read his annual report, and the Secretary read the report of the Auditing Committee as follows:

The undersigned, a duly appointed Committee, having examined the books of the Treasurer, find them correctly cast and properly vouched, and also that he has in his possession the securities called for.

CHARLES J. WHITE
 DAVID N. BLAKELY

Voted, To accept the Treasurer's report.

The Committee on Membership and Finance reported through Dr. Goss as follows:

The Committee on Membership and Finance respectfully recommends

That the petitions of the following for change in their district membership be granted.

Thomas E. Chandler from Norfolk to Suffolk
 George J. Ott " " " "
 Francis H. Slack " " " "
 Charles P. Sylvester from Norfolk South to Norfolk

That the resignations of the following be accepted:

William B. Cornell, Hathorne (now Baltimore)
Everett F. Darling, Worcester (now Brooklyn, N. Y.)
Helen W. Ham, Middleborough
Henry L. Houghton, Winchester
Frederick T. Hyde, Port Angeles, Wash.
Joseph H. Kenealy, Natick
John H. Lindsey, Washington Grove, Md. (now Washington, D. C.)
Carleton R. Metcalf, Concord, N. H.
Willis G. Neally, Brooklyn, N. Y.
Lawrence W. Strong, New York, N. Y.

Also that the following be placed on the retired list:

Henry J. Barnes, Northborough
Albert N. Blodgett, Boston
William P. Bolles, Roxbury
Lawton S. Brooks, Springfield
Francis J. Canedy, Shelburne Falls
Horatio F. Copeland, Whitman
George L. Ellis, Middleborough
George A. Jordan, Worcester
Moses G. Parker, Lowell
Martha Perry, Taunton
Franklin B. Stephenson, Pittsfield

Also that four thousand dollars (\$4000) of the balance in the treasury be distributed among the district societies.

Voted, To accept the report and adopt its recommendations.

Petitions from six former Fellows to be reinstated were read by the Secretary, and the following Committees were appointed to consider them:

For J. D. Clark. — W. D. Walker, J. P. Torrey, C. E. Abbott.
For M. Gerstein, for W. H. Davis, and for J. H. Costello. —
A. E. Sherburne, A. H. Davison, C. W. Macdonald.
For O. R. Fountain. — M. W. Pearson, A. G. Blodgett, E. D. Williams.

For J. W. McKoan. — R. W. Greene, R. J. Ward, C. B. Stevens.

In the case of the petition of W. H. Davis the Treasurer stated that he had sent bills and notices to Dr. Davis according to custom and that Dr. Davis had written him concerning them.

Voted, That these facts be communicated to the Committee appointed to consider his petition.

Dr. Ernst, for the Committee on Medical Education, submitted an extended report (see Appendix A, p. 27).

Voted, To accept the report and place it on file.

Dr. Withington, for the Committee on State and National Legislation, submitted a report (see Appendix B, p. 37).

Voted, To accept the report and place it on file.

On motion by Dr. F. C. Shattuck, a vote of thanks to Dr. Withington for his admirable report was passed unanimously.

Dr. M. W. Richardson submitted a report for the Committee on Public Health (see Appendix C, p. 42).

Voted, To accept the report and place it on file.

The Committee on the Workmen's Compensation Act reported progress, through Dr. Meigs. It was recommended by the Committee that this report be considered a report of progress and that the Committee be continued and report in full in the fall, at the next meeting of the council; and it was so voted.

The Librarian submitted his annual report and it was accepted.

Dr. Homer Gage, chairman of the Committee to revise the by-laws, submitted a revised draft of the by-laws, and explained that the draft submitted on May 10, 1913, to every Fellow of the Society had been amended in several places, giving the substance of the amendments and the reasons for making them. On motion of Dr. Goss, it was

Voted, That the council endorses these by-laws and directs that they be submitted to the Society at its next meeting for adoption.

On nomination by the President, the following Committees were appointed for the ensuing year:

Of Arrangements.

John Homans
Beth Vincent

W. W. Howell
J. D. Barney

E. L. Young, Jr.
Roger I. Lee

On Publications and Scientific Papers

G. B. Shattuck
J. S. Stone

E. W. Taylor

R. B. Osgood
F. T. Lord

On Membership and Finance.

F. W. Goss

C. M. Green
Samuel Crowell

A. Coolidge
F. W. Taylor

On Ethics and Discipline.

J. A. Gage

J. W. Bartol
G. deN. Hough

Henry Jackson
S. B. Woodward

On Medical Education and Medical Diplomas.

H. C. Ernst	H. D. Arnold	C. F. Painter
H. W. Newhall	J. F. Burnham	

On State and National Legislation.

C. F. Withington	F. G. Wheatley	G. W. Gay
	A. K. Stone	

On Public Health.

M. W. Richardson	M. J. Rosenau	W. I. Clark
A. L. Hamilton	E. H. Bigelow	

Drs. E. H. Stevens of Cambridge, and F. Jouett of Cambridge, were appointed delegates to the International Congress at London, England, August, 1913; and Dr. O. E. Johnson of Winthrop, was appointed delegate to the annual meeting of the British Medical Association at Brighton, England, July, 1913; and Dr. S. F. Haskins of Cotuit, was appointed to fill a vacancy in the Board of Censors of the Barnstable District.

The Nominating Committee, consisting of J. H. Higgins, H. G. Wilbur, E. H. Noyes, H. E. Sears, C. P. Hooker, M. W. Pearson, D. C. Dennett, E. H. Stevens, S. Crowell, E. N. Mayberry, A. E. Paine, F. C. Shattuck, D. Harrower, and E. A. Sawyer, brought in the following list of officers, and they were elected by ballot:

<i>President</i>	WALTER P. BOWERS, Clinton
<i>Vice-President</i>	LYMAN A. JONES, North Adams
<i>Secretary</i>	WALTER L. BURRAGE, Boston
<i>Treasurer</i>	EDWARD M. BUCKINGHAM, Boston
<i>Librarian</i>	EDWIN H. BRIGHAM, Brookline

Upon nomination by the Nominating Committee, Horace D. Arnold of Boston was appointed orator for 1914.

A letter from the New England Hospital Medical Society, calling the attention of the President of the Massachusetts Medical Society to the work of the women physicians of the state, Fellows of the Society, acting under the Committee for Public Health Education Among Women of the American Medical Association, was read by the Secretary; and it was

Voted, To place it on file.

Dr. Meigs of Lowell, read letters from Dr. Emma E. Young-Slaughter and Dr. Blanche A. Denig with reference to the work of the Committee for Public Health Education Among Women, and Dr. I. J. Clarke read a letter on the same subject from Dr. Denig to Dr. Symonds.

Voted, To place the letters on file.

A petition signed by forty-nine Fellows for a change in the

boundary line between the Suffolk and Norfolk Districts was read by the Secretary. On nomination by the President, the petition was referred to the following Committee:

Homer Gage, President of the Worcester District
J. S. H. Leard, President of the Norfolk District
H. D. Arnold, President of the Suffolk District

Dr. Hugh Cabot read a letter from Dr. Matthew Hale of the *Boston Journal*, stating that the *Journal* in line with its policy of furnishing clean, unbiased news to the public, refers all advertisements of patent medicines and questionable physicians to a medical board, of which Dr. Hugh Cabot is the head, for approval, the decision of this board being final. Dr. Cabot introduced the following resolution:

Having been advised of the policy recently inaugurated by the *Boston Journal* in regard to a censorship of medical advertisements, it is

Resolved, That the council of the Massachusetts Medical Society heartily approves of and endorses the policy of the *Boston Journal* in the censorship of medical advertisements and believes this to be an important step forward toward the cooperation between the medical profession and the press in matters pertaining to the public health.

The resolution being put to a vote was passed unanimously.

Adjourned at 1.50 P.M.

WALTER L. BURRAGE,
Secretary.

APPENDIX A.

REPORT OF THE COMMITTEE ON MEDICAL EDUCATION TO THE ANNUAL MEETING OF THE COUNCIL.

I have the honor to present herewith the report of your Standing Committee on Medical Education, of your delegate to the meetings of the conference of the American Medical Association on Medical Education and Medical Legislation, called by the Council on Medical Education and Council on Health and Public Instruction for February 24 and 25, 1913, in Chicago; also of your delegate to the Federation of State Medical Boards held at Chicago on February 25, 1913, and the Association of American Medical Colleges held in Chicago, February 26, 1913.

1. As to your Committee on Medical Education.

The activities of this Committee have been confined to its appearance before the Massachusetts Legislature in support of a bill taken from the files of last year, which should alter the present law in regard to the appearance of candidates for examination for licensure, in so far that such candidates should be obliged to possess a degree in medicine from a reputable college before making such application for examination. The fate of this bill has been the same as heretofore, excepting in a little different form, in that the Committee on Public Health reported "No legislation necessary," in relation to the recommendations of the State Board of Registration in Medicine.

2. The Conference of the Council on Medical Education and Council on Health and Public Instruction was held, as usual, in Chicago, on February 24 and 25. Of the programme the noteworthy points, as they appeared to your delegate, were the address of President Harry Pratt Judson of the University of Chicago, on the necessity of a readjustment of preliminary and collegiate education, in which he suggested a total of seven years for primary instruction and seven years for high school and college combined — this serving to bring the student to the professional schools at a considerably earlier age than is now the case.

A striking demonstration was given by Dr. Bradford, the Dean of the Harvard Medical School, of the present organization and clinical facilities of that school, which showed clearly its preeminent strength in facilities for teaching.

An address by Dr. H. D. Arnold, Dean of the Harvard Graduate School of Medicine, contained a general statement of the organization and plan of that new school, and was followed in discussion by remarks of Dr. V. C. Vaughan, Dean of the Medical School

of the University of Michigan, in which especial stress was laid upon the importance of a place for preventive medicine in the organization of any graduate instruction.

An exceedingly important point was made by Dr. Herbert Harlan, President of the Maryland State Board of Medical Examiners, on the importance of harmony and uniformity of the State Licensing Boards, in which he demonstrated — if this needed demonstration — that unless such harmony and uniformity can be brought about, confusion and disaster to the high ideals of the medical profession will result.

A somewhat startling proposed bill was brought forward by Mr. A. C. Umbreit, Attorney for the Wisconsin State Board of Medical Examiners, on state police power and the practice of medicine. The conditions of the bill were so far reaching and drastic in character that it is hardly to be expected that similar legislation can be uniformly consummated.

In the report of the members of the National Legislative Conference, the particularly interesting point was the statement made by the delegate from Vermont, that in that state a requirement had been passed in accordance with which it was necessary to report venereal disease, and provision had been made for furnishing free the so-called "Wassermann test," as well as free treatment for those unable to pay.

A notable occurrence was the presentation of a printed copy of the classified list of medical colleges in the United States, prepared by the Council on Medical Education of the American Medical Association, revised to January 15, 1913, and reprinted from the Journal of the American Medical Association, January 18, 1913.

In the grading adopted in this revised list there are four classes named:

Class A+. All acceptable medical colleges.

Class A. Colleges lacking in certain respects, but otherwise acceptable.

Class B. Colleges needing general improvement to be made acceptable.

Class C. Colleges requiring a complete reorganization to make them acceptable.

To your delegate this classification seems unnecessarily cumbersome, and its adoption leads to confusion in that colleges placed in Class B, and considered separate from the entire list, have an apparent rating higher than is in accord with the facts. It is interesting to see that, by this classification, there are twenty-two schools in Class A+ giving a full four years' course and two giving a two years' course. There are thirty-one in Class A giving a full four-year course, and six giving a two-year course. In Class B and C there is a total of fifty-five.

Still another interesting incident in this meeting was the presen-

tation of the reports of the members of the National Legislative Council made to the Council on Health and Public Instruction, in which a summary was given of the results of activity in regard to medical legislation in a number of the states — seventeen in all — and a report of the needs of the Army Medical Department, the Bureau of Medicine and Surgery of the Navy, and the United States Public Health Service. The details of these reports, so far as the interest is important, will be given by the Chairman of your Standing Committee on Medical Legislation.

Much was said at this meeting in regard to the intended activity of the Council on Medical Education in procuring the requirement of a fifth, or hospital, year. The importance of such a step is great, but the wisdom of requiring such hospital training before granting the doctorate of medicine is open to serious question. Unquestionably hospital experience should be required before a license to practice is granted, but it may be doubted whether such a requirement should be made before granting the degree in medicine.

The meeting of the Federation of State Medical Boards had an interesting series of papers upon its programme. The efforts of the members of this Federation towards uniform legislation in regard to requirements are worthy of all praise.

There was introduced a suggestion for a uniform card system for state license records, and a method for carrying out such a plan was suggested by the Biographical Department of the American Medical Association. The blank form suggested and submitted by that Department is attached herewith (see page 30).

The meeting of the Association of American Colleges consisted of reports of various committees, and an admirable address by the President on "Some Problems in Medical Education," discussed the proposed equipment standard, with a further statement of the proposed minimum standard for clinical equipment, included under the headings: A. — General, and B — Special, which require the possession of hospitals, dispensaries, clinical laboratories, and a library, and the form of which is indicated by the summary attached hereto (see page 33).

A long discussion was had in regard to a change in Article III of the Constitution and By-laws of this Association, in accordance with which requirements for entrance are fixed and definitely determined. This alteration was adopted and is shown upon the paper attached herewith (see page 35).

Respectfully submitted,

HAROLD C. ERNST.

*Chairman of Committee on Medical
Education and Delegate to the
Chicago meetings.*

A UNIFORM CARD SYSTEM FOR STATE LICENSE RECORDS.

To Secretaries of State Medical Licensing Boards:

GENTLEMEN:—Several secretaries of State Licensing Boards have written us relative to transferring their records from books to card-index systems, and have asked for suggestions. This has prompted a special study to determine the best form. Since other boards may be considering new record systems, it seems advisable to present the matter to all boards, as there would be special advantages in securing the use of a uniform card. We are presenting, therefore, proofs of two cards which have been prepared by modifying cards which have been in use in connection with the Directory and Biographical Index. Will you kindly suggest any additions or corrections, and also any changes in the arrangement of the subject-matter?

THE LARGE CARD.

It is suggested that this card be 4 inches by 6 inches in size. It is intended to be filed alphabetically by name, and would show the complete record of the licensee. On it will be recorded the following:

- Line 1. Name of licensee in full, surname to be given first.
- Line 2. Place and year of birth.
- Line 3. The preliminary education, such as name of college, high school or academy, year of graduation, degrees, received, etc.
- Line 4. The A. M. A. key abbreviation of medical school or schools at which he received his medical education and sessions attended.
- Line 5. The A. M. A. key abbreviation of medical school or schools from which applicant graduated and year of graduation.
- Line 6 and 7. Basis on which he received his license, such as by examination, reciprocity or otherwise.
- Line 8. Other states where applicant may have obtained licenses and years when they were obtained.
- Line 9. Application number, certificate number and date when license in your state was issued.
- Lines 10 to 16, inclusive. This space is for present address and new addresses with date of changes. From left to right the space is provided for (a) date of change of address, (b) name of city or town (street number also if large city), (c) name of county, and (d) date of county registration.

Sample of Large Card.

Saunders, John E.			
Liverpool, Ohio, Oct. 1, 1884.			
Liverpool High School, 1905.			
Ill. 1, 07-08	Ill. 1, 08-09.	Ill. 1, 09-10.	Ill. 1, 10-11.
Ill. 1, 1911.		Md. 7, 1912.	
<input type="checkbox"/> Examination.		<input type="checkbox"/> Years of Practice.	
<input type="checkbox"/> Reciprocity.		<input type="checkbox"/> Diploma.	
Ill. '11.	Md. '12.	Mass. '14.	
Appl. No. 6262.		Certif. No. 1334.	July 7, 1911.
10/1/11.	Aurora.	Kane.	1911.
7/1/12	Elgin.	"	1912.
(a)	(b)	(c)	(d)

THE SMALL CARD.

It is suggested that this card be 3 inches by 5 inches in size. It is intended to be kept in a file arranged by cities. Record of registration of license certificates by county clerks can be kept on this card. On it will be recorded the following:

Line 1. Name of licensee in full, surname given first.

Line 2. Licensee's application and certificate numbers and date when license in your state was issued.

Lines 3 to 12, inclusive. This space is for present address and new addresses with date of changes. From left to right space is provided for (a) date of change of address, (b) name of city or town (street number also if large city), (c) name of county and (d) date of county registration.

Sample of Small Card.

Saunders, John E.			
Appl. No. 6262.		Certif. No. 1334.	July 7, 1911.
10/1/11.	Aurora.	Kane.	1911.
7/1/12.	Elgin.	"	1912.
(a)	(b)	(c)	(d)

ARGUMENTS FAVORING THIS UNIFORM CARD SYSTEM.

It is a unit system: Each card shows the record of one licensee; cards can be always kept alphabetically; they can be more conveniently handled, and it will save in the future the work of copying records from one book to another.

It will be a time-saver. A man's record can be found in an instant; corrections can be readily made; several persons can use card index at one time, where only one person can use a book.

It is a flexible system permitting of unlimited growth. New matter can be easily inserted; dead material can be easily eliminated; space for changes of address is provided; in brief, the records can very easily be kept up to date.

It would prove to be an excellent system for the interchange of records between states and in preparing reports, such as those which the boards are so kindly furnishing to the American Medical Association.

The general adoption by large business houses proves a card system to be far superior to a book record, and since card records are filed in special cabinets, which can be locked, they are always more privately, securely and cleanly kept.

A card generally used throughout the country could be printed in larger quantities, and therefore furnished the individual states

in any quantity desired at a lower expense than could otherwise be possible. In the case of the 4×6 card, printed in quantities of 100,000 or more, the cost for each state would be at the exceedingly low rate of \$1.25 per thousand. In the same manner the 3×5 cards could be furnished at \$1 for each thousand. Furthermore, additional supplies could always be obtained at the same low rate and furnished immediately on request.

The adoption of this card would be of particular benefit in keeping the records of new licensees. For those already licensed your records may not give all the information asked for on these cards but such information as you have could be filled in and the other data could be recorded from time to time as the information is received.

We would respectfully ask you to give the subject early consideration and favor us with your views, both as to the cards and the general system.

Thanking you in advance for your cooperation in this matter, we remain,

Yours very truly,

BIOGRAPHICAL DEPARTMENT,
AMERICAN MEDICAL ASSOCIATION.

SUMMARY OF EQUIPMENT STANDARD.

In the "Equipment Standard," adopted by the Association, March 16, 1908, as "a tentative working basis for further development," the following clinical equipment is specified:

Clinics. Two beds per senior student (16 patients).

Dispensary. Fifty patients per senior student.

Obstetrics. Five cases per senior student.

Operative Surgery. Cadavers. Living Animals.

Clinical Diagnosis. Equipment for examining exudates, secretions, excretions, blood and tissues (may be taken from other departments).

Electrotherapeutics. Well equipped dark-room; induction coil or static machine; high-frequency resonator; fluoroscope; electrodes; mercury turbine or other interrupter; rheostat; x-ray tubes (therapeutic and diagnostic); tube rack and stand.

Library. One publication on general medicine and one publication devoted to the work of each department. Text-books. Library must be catalogued and available for use.

PROPOSED MINIMUM STANDARD FOR CLINICAL EQUIPMENT.

A. General.

1. *General Hospital* (owned or controlled by school for clinical teaching) must be provided with minimum daily average of 100

available bed-patients, representing the various phases of medicine and surgery, and with adequate rooms and equipment for clinical teaching. For classes of 50 or more the minimum is 2 patients daily per senior student.

2. *Dispensary or Out-Patient Department* must be provided, managed by school, with minimum daily average of 40 patient-visits, and for the school year not less than 120 patients per junior and senior student. The Dispensary must have adequate rooms, equipment and patients for clinical instruction in medicine and surgery, including their principal subdivisions.

3. The organization and equipment must provide for thorough individual clinical instruction both in hospital wards and dispensary, with at least 1 competent instructor to every six students. Complete clinical records must be kept both in hospital and dispensary. Above all, equipment and facilities must be intelligently used in the training of students.

B. Special.

1. *Clinical Laboratory.* — Adequate rooms, equipment and facilities must be provided especially for microscopical, chemical and bacteriological examinations of clinical materials. These facilities must be accessible to every student during at least the entire senior year.

2. Adequate rooms and equipment must be provided for X-ray work and for electrotherapeutics.

3. In *surgery* equipment and materials must be provided for thorough courses in operative surgery on the cadaver and upon animals. In addition, facilities must be provided to allow each student to assist in at least 6 major operations and to administer a general anesthetic at least 6 times under competent supervision.

4. In addition to obstetrical charts, models, specimens and equipment for manikin drills, etc., clinical facilities must be provided which will allow each senior student, under proper supervision, to witness at least 12 confinement cases, at least 3 of which he shall have entire charge of, also under proper supervision, before, during and after labor.

5. Equipment and facilities must be provided so that each student shall observe and take part in at least 12 complete autopsies.

Library.

The college should have a working medical library. It should include the more modern text and reference books, the *Index Medicus*, and 30 or more leading medical periodicals representing all the various departments. The library should be catalogued and accessible to students at all times.

ADMISSION REQUIREMENTS FOR MEDICAL COLLEGES.

A diploma and transcript of record from an accredited high school, normal school or academy requiring for admission evidence of the completion of an eight-year course in primary and intermediate grades and for graduation not less than four years of study, embracing two years (2 units) of mathematics, two years (2 units) of English, two years (2 units) of a foreign language, one year (1 unit) of American history and seven years (7 units) of further credit in language, literature, history or science, making the total of units at least fourteen and one year each of physics, chemistry and biology of college grade of each not less than six semester hours. If any organization mentioned in Section 3 of this Constitution recognizes any high school work as of college grade it shall be accepted as such.

An examination in the following branches totaling 14 units:

(A) Required, 7 units.	Units.
Mathematics — (Minimum 2 years; maximum 3 years)	2
English — (Minimum 2 years; maximum 4 years)	2
A foreign language — (Minimum 2 years; maximum 4 years)	2
History U. S. Total required	1
	<hr/>
Total number of units required	7

(B) Elective, 7 units.	Units.
To be selected from the following:	
English Language and Literature — (In addition to the required work)	1 to 2
Foreign Language — Additional, Latin, German, Italian, French, Spanish or Greek, (not less than 1 year in any one)	1 to 4
Advanced Mathematics, Advanced Algebra, Solid Geometry and Trigonometry ($\frac{1}{2}$ year each)	1
Natural Science — Biology, including Botany, Physiology and Zoology ($\frac{1}{2}$ to 1 year each)	$\frac{1}{2}$ to 2
Earth Science — Physical Geography, Geology and Agriculture ($\frac{1}{2}$ year to 1 year each)	$\frac{1}{2}$ to 2
Astronomy — ($\frac{1}{2}$ year)	$\frac{1}{2}$ to 1
Drawing — ($\frac{1}{2}$ to 1 year)	$\frac{1}{2}$ to 1
History — Ancient and Modern, English (1 year)	1
Economics — ($\frac{1}{2}$ year)	$\frac{1}{2}$ to 1
Manual training	$\frac{1}{2}$ to 1
Bookkeeping ($\frac{1}{2}$ to 1 year)	$\frac{1}{2}$ to 1

One unit in any subject is the equivalent of work in that subject for five periods per week for thirty-six weeks, periods to be not less than forty-five minutes in length. One unit is equivalent to 2 semester credits or 2 points.

APPENDIX B.

REPORT OF THE COMMITTEE ON STATE AND NATIONAL LEGISLATION TO THE ANNUAL MEETING OF THE COUNCIL.

The Committee on State and National Legislation of the Massachusetts Medical Society begs leave to make the following report regarding the legislative incidents of the winter. It desires to express obligation to the Auxiliary Committee in which have been included some committees which have been appointed by district societies, and also to the medical members of the legislature who have generally been active in advancing measures for public health.

The State Board of Health was made the subject of a bitter attack in several bills, most of which provided for the abolition of the present largely unpaid board and the creation of a highly salaried board, positions upon which would be not unattractive to some of the advocates of these bills and their friends.

The bill embodying most strongly this attack was reported by a majority of the Committee on Public Health but was rejected by the Ways and Means Committee. Nevertheless, it was substituted by the House and carried through and passed. Reconsideration, however, was obtained, largely through the efforts of a member (Dr. Bigelow of Framingham), and the bill was killed by a small majority.

In the matter of milk legislation the Ellis milk bill again failed of passage, the opposition of the dairy interests being undiminished.

A bill for the sale of milk, introduced by the Mayor of Boston, authorizing boards of health to issue permits for the sale of all milk and cream, and forbidding the use of milk produced, transported, or kept under conditions unsatisfactory to the local board, was lost.

A bill labelling all receptacles of pasteurized or out-of-state milk was passed, but has just been vetoed by the Governor (June 9).

A bill limiting the number of bacteria admissible in milk was lost.

In the matter of the Workmen's Compensation Act, two bills to permit an injured person to select his own physician were rejected in the Senate, but, on conference with the Industrial Accident Board, insurance companies agreed to permit the injured person to select his own physician.

A bill introduced by the Chairman of the Industrial Board is well advanced toward passage, providing compensation in case

a hand, foot, etc., are made permanently incapable of use, as well as if the member be lost.

Many other proposed amendments to the existing act were offered but failed of passage.

Various bills, attacking the work of the Board of Registration in Medicine and seeking to break down its examination, failed of passage. Some of these were pushed with great vehemence. One such, after requiring that the examination for registration be made wholly in writing, provided that an adverse decision of the board might be reversed by three physicians appointed by a judge of the Superior Court to examine the candidate's papers.

A bill to consolidate the Board of Registration in Medicine with that of Dentistry and Pharmacy was defeated.

On the other hand, unfortunately, a bill requiring the possession of a degree from a legal, authorized medical school as a prerequisite to taking the examination for registration was lost.

A bill, asked for by the Board, permitting the reinstatement of certain physicians by the Board, was passed (Chap. 346).

A bill was introduced by the Fall River Chamber of Commerce for a "definite policy in the treatment of tuberculosis." This bill not only put the supervision and control of all sanatoria, public and private, under the State Board of Health, but required the latter to take over all existing public tuberculosis hospitals and to take land for and to erect all future ones, thus throwing the whole expense of provision of sanatoria upon the State. This latter feature was deemed objectionable by the Boston Association for the Relief and Control of Tuberculosis and by many others, as well as by your committee, and was defeated.

Desirable Bills which Failed of Passage.

1. To prevent infantile blindness; rejected by the Senate.
 2. Improving the sanitary condition of Charles River.
 3. Appointing a commission on child labor.
 4. Admission, in certain cases, of expert medical testimony.
- This was a bill favored by the American Institute of Criminal Law and Criminology and by certain physicians, establishing the qualifications of medical experts and authorizing the Court, on the application of counsel for the respective parties, to name one or more medical experts to testify on all questions requiring expert medical evidence during the trial, the respective parties waiving the right to all other expert witnesses.

Other Bills which Failed of Passage.

1. Three bills concerning adulteration of food and drugs.
2. Appeals from boards of health authorizing a person denied, on the ground of injury to public health, permit or license for the use of his real property by a board of health other than that of

Boston, to appeal to the board of aldermen or selectmen, who may overrule the decision of the health board.

3. Authorizing the City of Boston to appoint nurses and also giving the same authority to the school committee.

4. Two antivaccination bills, — one, allowing public school children to be exempt from compulsory vaccination, on the request of their parents; the other, for so-called "purity of vaccine virus" (conditions impossible of carrying out and designed to hinder vaccination).

5. Two bills regulating the practice of dentistry. 1. Authorizing the registration of so-called dental nurses, to perform certain duties under the direction of a registered dentist. 2. Requiring reregistration of all dentists every year.

6. Prohibiting the use of common drinking cups in public places, etc. Previous legislation gave authority to the Board of Health to prohibit such cups but this bill cancelled that authority and replaced it by an absolute prohibition. The bill having passed, was vetoed by the Governor, and the authority now is left, as before, to the Board of Health.

7. Prohibiting the use of any room below the street level as a dwelling place.

8. A bill on prescribing hypnotic and narcotic drugs. This was introduced by the Watch and Ward Society and required every practitioner to keep a record for two years, open to inspection, of each patient, receiving such a drug, of each occasion of giving it, with the name of the disease, etc.

9. A less onerous bill, substituted by a medical member, was also defeated.

10. A bill for medical attendance of needy poor, carrying an appropriation of \$200,000.

11. A bill on regulation of the making of matches and prohibiting the use of certain kinds of matches.

12. A bill authorizing any medical school to request the State Board of Registration in Medicine to issue to medical students certificates of qualification for admission, without which validating certificates no student should be admitted to any school which applies under this act. This bill was intended to guarantee that schools shall really enforce the admission requirements which they profess to require.

13. A bill for furnishing medical services to persons arrested for drunkenness, if the arrested person so requests.

14. A bill for the registration of nurses, requiring the possession of a diploma as a prerequisite to the bestowal of the letters "R.N.," such diploma to be from a training school "considered efficient" by the Board of Registration of Nurses. This was objectional, on the grounds, first, that it would practically debar male nurses from the title R.N., and second, it would confer on one person, herself a registered nurse, the right to make an investigation for the Board of the efficiency of any school, thereby giving undesirable power to one person.

15. A bill to regulate the practice of "suggestive therapeutics." Any person holding a diploma from a regular chartered school may have the same approved by a "county or probate judge," upon the payment of \$10, and receive from the judge a license to practice.

16. A bill for the registration of midwives. This provided no supervision over the training, cleanliness, or knowledge of midwives, but by registering them would give them a status which they do not now possess. Its advocate took into account only the securing of better vital statistics but did not consider the question whether it was better to record births than to produce deaths. In other words, whether the measure was more potent for vital statistics than for lethal results.

The following bills are at date under way to be passed but have not reached their final stage.

1. To provide permanent accommodations for defective delinquents (passed the House).

2. To provide temporary accommodations for the same (passed the House).

3. For a commission to find a way to decrease drunkenness.

4. For a codification of the health laws in the State (passed the House).

5. Reducing the hours of women and minors in manufactories, to 10 hours a day, and 54 hours a week.

6. For the aid of mothers with dependent children.

7. Prohibiting the making of clothing in tenement houses.

8. A child labor bill, providing the maximum of 8 hours a day, or 48 hours a week, for children from fourteen to sixteen years of age, in factories, and forbidding factory labor to children under fourteen years (passed the House).

9. For examination of persons arrested, at the place where such persons are first taken. Any injuries visible without removal of clothing to be reported at once by the officer in charge of the jail or station, to the Chief of Police, or, in Boston, to the Police Commissioner.

The Following Bills were Passed.

1. For reporting automobile accidents (Chap. 530).

2. For punishing reckless drivers of automobiles (Chap. 123).

3. Providing boxes and baskets to be used in mills by women (Chap. 426).

4. That counties may maintain bacteriological laboratories, no expenditures to be made until laboratory facilities have been approved by the State Board of Health (Chap. 328).

5. Prohibiting the sale of eggs unfit for food, also their use in preparation of food products (Chap. 654).

6. Regulating the sale of unwholesome food, — meat, fish, vegetables, produce, fruit, or provisions of any kind (Chap. 687).

7. Regulating the use of hat pins (Chap. 256).

8. For the care of lepers. The State Board of Charity to retain in the leper hospital all lepers as long as the Board deems necessary for the well being of the patient and of the public (Chap. 37).

9. Sale of liquor by pharmacists. The Board of Registration in Pharmacy, on the payment of a fee of \$5, to issue to any pharmacist a certificate of fitness upon which the pharmacist may sell alcohol, without a physician's prescription, and liquors only on prescription (Chap. 413).

10. Relative to the sale of molluscs taken from polluted waters (Chap. 504).

11. An amendment to the law of tenement houses. This was introduced by the Civic League, is an amendment to the important act of 1912 (Chap. 635), and extends the operation of the provisions of that law to two-family tenements (Chap. 614).

12. Subsidies for supporting tuberculosis hospitals (Chap. 145).

13. To prohibit candy containing more than 1 per cent of alcohol (Chap. 647).

14. For the branding of certain carcasses (Chap. 570).

15. The reporting of deaths from diseases dangerous to public health (Chap. 210).

16. For the investigation of infectious diseases (Chap. 670).

17. Prohibiting the practice of pharmacy by unregistered persons. "Personal supervision" means that a registered pharmacist is in charge and present in the store (Chap. 720).

18. A bill authorizing cities and towns to provide meals for school children (Chap. 575).

The Following Resolves were Passed.

1. Allowing \$10,000 for investigation, under the direction of the Board of Health, of poliomyelitis.

2. A resolve that the State Boards of Health and Insanity jointly investigate and report with drafts of bills in January, 1914, what further impediments to marriage should be required by this Commonwealth (R. 85).

3. A resolve in favor of the Massachusetts Charitable Eye and Ear Infirmary (R. 23).

4. For an examination into the condition and correction of those with defective vision (R. 97).

5. In favor of New England School for Deaf Mutes, appropriating \$3,500 (R. 24).

In the matter of national legislation, there is nothing to report save that the Owen bill, which has again been recast by its author, is considered to be in better prospect of passage than ever before, as Senator Owen has been reelected for a term of six years. Other matters in Congress are now occupying the center of the stage.

Respectfully submitted,
Charles F. Withington
for the Committee.

APPENDIX C.

REPORT OF THE COMMITTEE ON PUBLIC HEALTH TO THE ANNUAL MEETING OF THE COUNCIL.

The Committee on Public Health of the Massachusetts Medical Society begs leave to present the following as its second annual report.

As a Committee and individually the members of the Committee have been active in various ways. Many matters affecting public health have been brought more or less informally to the attention of the proper authorities.

The Committee has cooperated with other committees of the Society and with other organizations interested in public health. Dr. Annie Hamilton, Chairman of the New England Committee of Public Health Education Among Women of the American Medical Association, has attended some of the meetings of the Committee and has been of great assistance to us. Through Dr. Hamilton a number of matters vitally concerning the public health were brought to the attention of the Federation of Women's Clubs and the Municipal League of Boston. It has been the policy of the Committee to utilize already existing organizations and committees wherever possible in furthering public health activity.

During the year a circular letter was sent to the secretaries of all the district societies asking for cooperation and suggesting that at least one meeting of each society be devoted to some problem of public health. This letter met with a most satisfactory response on the part of the district societies. The Committee has also kept in touch with the Council on Health and Public Instruction of the American Medical Association. The Committee made some important recommendations in a communication to the meeting of the Council of the Massachusetts Medical Society, held on February 5.

In the opinion of the Committee the principles involved in this communication were fundamental to the success of the public health movement. They concerned the improvement of the local health situation. All the four propositions in this communication were indorsed at a meeting of the Council on February 5, 1913. The Committee on Public Health then sent to each of the district secretaries a copy of this vote of the Council with a request that it be read at the next meeting of the district society. The Committee feels that its work has merely begun. In view of the vast importance and scope of the work on Public Health

it is the intention of the Committee to attempt to do intensive and constructive work on a relatively few subjects during each year.

M. W. RICHARDSON, *Chairman*

M. J. ROSENAU

L. A. JONES

W. I. CLARK, JR.

R. I. LEE, *Secretary.*

Massachusetts Medical Society

PROCEEDINGS
of the
SOCIETY

June 10 and 11, 1913.

Massachusetts Medical Society

PROCEEDINGS OF THE SOCIETY.

ANNUAL MEETING.

FIRST DAY.

JUNE 10, 1913.

MEETINGS OF SECTIONS were held in the Copley-Plaza Hotel, Boston, on Tuesday, June 10, 1913. The sections were officered and papers presented according to the following programme:

MEETINGS OF SECTIONS.

MEETING OF THE SECTION OF MEDICINE.

Salon, Copley-Plaza Hotel, 2.30 o'clock.

Officers of the Section of Medicine.

DR. HORACE D. ARNOLD, Boston, Chairman.

DR. THEODORE J. EASTMAN, Boston, Secretary.

Symposium on Nephritis.

1. The Classification of Nephritis from the Pathological Point of View (with lantern slide demonstration). — Dr. Frank B. Mallory, Brookline.

2. Clinical Functional Tests and Methods:

(a) The Significance of Urinary Acidity in Nephritis. — Dr. Walter W. Palmer, Boston.

(b) The Phenolsulphonaphthalein Test. — Dr. Edward L. Young, Jr., Boston.

(c) Tests for Renal Function Based Upon the Selective Excretory Activities of the Kidney. — Dr. Reginald Fitz, Boston.

3. Nitrogenous Waste Products in the Blood in Nephritis:

(a) Their Significance and the Methods for Their Determination. — Dr. Otto Folin and Dr. William Denis, Boston.

(b) Their Effects in Chronic Interstitial Nephritis: — Dr. Malcolm Seymour, Boston.

4. General Summary of the Significance of Methods of Testing Renal Function. — Dr. Henry A. Christian, Boston.

There were 150 in attendance.

MEETING OF THE SECTION OF SURGERY.

Ballroom, Copley-Plaza Hotel, 2.30 o'clock.

Officers of the Section of Surgery.

DR. JOHN T. BOTTOMLEY, Boston, Chairman.

DR. ROBERT B. OSGOOD, Boston, Secretary.

1. An Anatomical and Surgical Study of Peri-Cecal Membranes. — Dr. Michael F. Fallon, Worcester.

Discussion by Dr. J. C. Hubbard, Boston, and Dr. S. A. Mahoney, Holyoke.

2. The Relationship between Gynecological and Neurological Diseases. — Dr. William P. Graves, Boston.

Discussion by Dr. W. L. Burrage, Boston, and Dr. Stephen Rushmore, Boston.

3. Observations on a Series of Ninety-eight Consecutive Operations for Chronic Appendicitis. — Dr. Ernest A. Codman, Boston.

Discussion by Dr. P. P. Johnson, Beverly, Dr. J. B. Blake, Boston, and Dr. S. A. Mahoney, Holyoke.

4. Certain Observations upon Two Hundred Cases of Gastric Disease. — Dr. Charles L. Scudder, Boston.

Discussion by Dr. F. B. Lund, Dr. D. F. Jones, Dr. E. A. Codman, Dr. T. W. Harmer, Boston, Dr. F. T. Murphy, St. Louis.

5. The Value of the Roentgen Method in the Study of Chronic Appendicitis, and Inflammatory Conditions, both Congenital and Acquired, about the Cecum and Terminal Ileum. — Dr. Ariel W. George, Cambridge, and Dr. Isaac Gerber, Boston.

There were 180 in attendance.

MEETING OF THE SECTION OF TUBERCULOSIS.

State Dining Room, Copley-Plaza Hotel, 2.30 o'clock.

Officers of the Section of Tuberculosis.

DR. J. F. A. ADAMS, Pittsfield, Chairman.

DR. JOHN B. HAWES, 2ND, Boston, Secretary.

1. The Importance of Education in the Tuberculosis Campaign. — Dr. Lyman Asa Jones, North Adams.

2. The Tuberculosis Problem in Cities and Towns from the Point of View of Local Boards of Health. — Dr. Bradford Peirce, Cambridge.

3. The Need of Cooperation between Local and State Forces in Tuberculosis Work. — Dr. John B. Hawes, 2nd, Boston.

Discussion by Dr. W. C. Bailey, Boston, Dr. E. Washburn, Taunton, Dr. E. O. Otis, Boston, Dr. A. C. Getchell, Worcester, Dr. C. E. Prior, Malden, Dr. F. H. Fuller, Walpole, Dr. I. J. Clarke, Haverhill, Dr. A. K. Stone, Boston, and by Dr. J. B. Hawes, 2nd, Boston and Dr. B. Peirce, Cambridge.

There was an attendance of 100.

The officers of the Sections for the ensuing year were elected by the Sections as follows:

Section of Surgery. — Chairman, R. H. Seelye, Springfield; Secretary, E. P. Richardson, Boston.

Section of Medicine. — Chairman, L. A. Jones, North Adams; Secretary, Gerald Blake, Brookline.

Section of Tuberculosis. — Chairman, A. C. Getchell, Worcester; Secretary, J. B. Hawes, 2nd, Boston.

The Shattuck Lecture was delivered in the Copley-Plaza Hotel, in the evening, by Dr. Harvey Cushing of Boston. Subject: Diabetes Insipidus and the Polyurias of Hypophysial Origin.

At the close of the lecture there was a reception to the President and a popular concert, at which the attendance was about nine hundred.

SECOND DAY.

JUNE 11, 1913.

The Society met at the Copley-Plaza Hotel, Boston, on Wednesday, June 11, 1913, for the exercises of the one hundred and thirty-second anniversary. The President, Dr. Walter P. Bowers, was in the chair, and forty-four Fellows were present at the opening of the meeting. The records of the last meeting were read and accepted. The Secretary announced that during the past year the society had lost 46 Fellows by death, 12 by resignation and 44 by deprivation of the privileges of fellowship, making a total loss of 102. The Society had gained 151 members, — by restoration to fellowship, 6 (restored by the Council, 4; readmitted by the Censors, 2), new members, 145, — making the total membership on that day, 3431.

ADMISSIONS REPORTED FROM JUNE 13, 1912, TO JUNE 11, 1913.

The following are the lists of admissions and deaths for the year:

Year of Admission	Name	Residence	Medical College
1913	Abbott, Charles Roger	Worcester	22
1913	Albert, Lionel Louis	Boston	12
1913	Allard, Carlton Eugene	Boston	12
1912	Archambault, Lionel Maximillian	Haverhill	7
1912	Austin, Arthur Everett (readmitted)	Boston	11
1913	Baldwin, Walter Isaac	Boston	1
1912	Ball, Arthur Nelson	Northampton	21
1913	Barrie, Emile August	Lowell	12
1912	Bauer, Louis Hopewell	Springfield	11
1912	Baum, Ewald George	Natick	3
1912	Beardsley, William Henry	Springfield	2
1912	Blaisdell, John Harper	Lynn	11
1913	Blanchard, Paul Drake	Lowell	12
1912	Bodwell, William Mortimer	Framingham	14
1912	Boland, Lawrence Francis	Fitchburg	8
1913	Bowen, Enos Emanuel	East Boston	10
1912	Bowen, James Francis	Amherst	22
1913	Brennan, Daniel Clark	Worcester	11
1912	Brides, Arthur Edward	Springfield	23
1912	Brigham, Francis Gorham	Boston	11
1912	Brown, Chester Perkins	Salem	12
1913	Buckley, George Ambrose	Worcester	11
1913	Burrell, Harry Cutter	Medford	12
1912	Canney, Ellen Rose	New Bedford	13
1912	Carr, Christopher James	Saxonville	21
1913	Carvell, Hanford	Gloucester	8
1912	Casey, John Francis	Allston	17
1912	Cassels, Louis Raymond	Worcester	12
1913	Charbonneau, Noe Napoleon	Grafton	22
1912	Church, Claude Henry	Fitchburg	12
1913	Claffy, John McMahon	Springfield	22
1913	Clark, Frank Robinson	Newtonville	11
1913	Clarke, Thomas Greene	Boston	12
1912	Cobb, Gardner Nathan	Gardner	14
1912	Cody, Edmond Francis	New Bedford	11
1913	Condric, John Joseph	Brockton	22
1913	Conley, Brainard Francis	Malden	12
1912	Cooney, Margaret Blanche	Haverhill	12
1913	Cornish, Solon Washington	Everett	11
1912	Cotter, Timothy Francis	Haverhill	8
1913	Couch, Mary Catherine	Northampton	12
1912	Cross, Albert Elmer	Worcester	10

Year of Admission	Name	Residence	Medical College
1912	Currier, Cyrus Richardson	Sandwich	12
1912	Cutler, George David	Boston	11
1913	Dalton, Charles Howard	Brookline	24
1913	Davis, Frederick Durand	Westfield	22
1913	Edsall, David Linn	Boston	19
1913	Ely, Theodore Williams	Boston	18
1912	Eustis, Richard Spelman	Boston	11
1912	Fallon, Joseph Francis	Brookline	20
1912	Finkelstein, Nathan	Pittsfield	12
1913	Finnegan, Francis Augustine	Lowell	11
1913	Fitz, Reginald	Boston	11
1913	Foley, Thomas Brinsley	Boston	25
1913	Fraser, William Leslie	Lynn	9
1912	Gallagher, Nicholas Ambrose	Malden	4
1912	Gardner, Edwin Daniels	New Bedford	11
1913	GariPAY, Ellsworth Peter	Lynn	12
1912	Glunts, David	Boston	12
1913	Grady, Thomas Francis	Lynn	11
1912	Hamblen, Howard	Maynard	12
1912	Hardwick, Everett Vinton	Dorchester	11
1913	Haslan, Frank Alden	Roxbury	11
1912	Hemeon, Frederick Chipman	Dorchester	20
1912	Hennessey, Thomas Francis	Lynn	12
1913	Hill, Lawrence Richardson	Pittsfield	11
1913	Hoberman, Samuel	Malden	3
1912	Hopkins, John Wilson	Melrose	3
1912	Howes, Frank Miller	Fairhaven	11
1912	Irving, Frederick Carpenter	Boston	11
1913	Jantzen, Francis Thomas	Boston	11
1913	Johnson, Harold Abbott	Lynn	11
1912	Kellogg, Foster Standish	Boston	11
1913	Kemp, Howard Martin	Turners Falls	8
1913	Kendrick, Joseph Thomas	Dorchester	12
1913	Kenney, Clarence Bronson	State Farm	12
1912	LaMoure, Charles TenEyck	Gardner	15
1913	Leary, Patrick Frank	Turners Falls	22
1912	Leeper, Marion Eleanor	Northampton	13
1913	Leonard, Ralph Davis	Melrose	11
1913	Lewis, Frank Edward	Boston	14
1912	Lincoln, George Chandler	Worcester	11
1912	Lored, Serafin Marine	Worcester	12
1913	Luce, LeRoy Alson	Boston	12
1912	Luftig, Jacob	Boston	16
1913	MacFadyen, John Alexander	Worcester	22
1912	Macomber, Donald	Boston	11
1913	Mahoney, Walter Francis	Westboro	12
1912	Marble, Henry Chase	Boston	11

Year of Admission	Name	Residence	Medical College
1913	Marr, Edward Loring	Melrose	12
1912	Marr, Robert McClellan	Springfield	12
1913	Martin, Edward	Roxbury	12
1913	Martin, Harold Winthrop	Dorchester	12
1913	Mason, Gilbert McClellan	Dorchester	10
1913	McCann, Charles Daniel	Brockton	11
1913	McCarty, Franklin Bennett	Brookline	11
1912	McConnell, David James	Greenfield	22
1912	McKelvey, Alexander Dunbar	Boston	26
1912	Metzger, Butler	Lynn	11
1912	Miller, Richard Henry	Boston	11
1912	Mindlin, Carl	Haverhill	9
1912	Minot, George Richards	Boston	11
1913	Murphy, John Joseph	Cambridge	11
1913	Murphy, Joseph Leroy	Boston	11
1912	Newburgh, Louis Harry	Boston	11
1912	O'Brien, Edward Joseph	Roxbury	12
1913	O'Meara, John George	Providence, R. I.	19
1913	Packard, Loring Bradford	Brockton	11
1912	Papoulacos, Panagiotis	Boston	27
1913	Pemberton, Frank Arthur	Boston	11
1913	Perras, Louis Adélar	New Bedford	8
1913	Perry, Harold Edgar	New Bedford	11
1913	Peterson, Hugo Oliver	Worcester	11
1912	Porter, Charles Hunt	Springfield	17
1913	Quennell, Willard Leslie	Lynn	12
1912	Rackemann, Francis Minot	Boston	11
1912	Reggio, André William	Boston	11
1913	Reynolds, Ralph Leavitt	Waterville, Me.	11
1913	Richards, Cyril Godfrey	Dorchester	12
1912	Ryan, William Francis	Lowell	20
1912	Salles, John Murray	New Bedford	8
1912	Scanlan, Maurice Thomas	Dorchester	12
1912	Schadt, George Leonard	Springfield	19
1913	Shaunahan, Richard Joseph	Worcester	17
1912	Sheldon, Russell Firth	Boston	11
1912	Shepherd, William Gordon	Lynn	26
1912	Simon, Arthur Leslie	Lawrence	12
1913	Sprague, Russell Bradford	Boston	12
1913	Steeves, Ernest Colpitt	Essex	14
1913	Stevens, William Stanford (read- mitted)	Boston	11
1912	Stone, Jane Gray	Boston	12
1913	Sullivan, Leo Jeremiah	Fall River	7
1912	Sweeney, Bartholomew Philip	Fitchburg	8
1913	Temple, William Franklin, Jr.	Boston	11
1912	Thomas, Elmer Ellsworth	Northampton	12

Year of Admission	Name	Residence	Medical College
1913	Tilton, Earle Edward	Boston	12
1912	Titus, Raymond Stanton	Boston	11
1913	Torrey, Arthur Stanley	Gloucester	14
1912	Tripp, Edwin Prescott	West Roxbury	12
1912	Turnbull, Frederick Myles	Jamaica Plain	24
1912	Turnbull, John Archibald	Jamaica Plain	24
1912	Underhill, Elizabeth Colden	South Hadley	16
1913	Walker, Clifford Black	Boston	6
1913	Ward, William Greenleaf	Lynn	11
1913	Weller, John Henry	State Farm	7
1912	Wetherbee, Lucy Emma	Worcester	10
1913	Wilson, Charles Moore	Salem	5

Total 145 + 2 = 147.

- 1 University of California, Medical Department.
- 2 Yale University Medical Department.
- 3 George Washington University, Department of Medicine.
- 4 University of Georgetown, Medical Department.
- 5 Medical School of Maine.
- 6 Medical Department of the Johns Hopkins University.
- 7 College of Physicians and Surgeons, Baltimore, Md.
- 8 Baltimore Medical College.
- 9 Long Island College Hospital.
- 10 Boston University School of Medicine.
- 11 Harvard University, Medical School.
- 12 Tufts College Medical School.
- 13 University of Michigan, Department of Medicine and Surgery.
- 14 Dartmouth Medical School.
- 15 Albany Medical College.
- 16 Cornell University Medical College.
- 17 Columbia University College of Physicians and Surgeons.
- 18 Medical Department of Western Reserve University.
- 19 Department of Medicine, University of Pennsylvania.
- 20 Jefferson Medical College.
- 21 Medico-Chirurgical College of Philadelphia.
- 22 University of Vermont, Medical Department.
- 23 University of North Carolina, Medical Department.
- 24 McGill University, Medical Department.
- 25 Faculty of Medicine of Queen's University.
- 26 Toronto University, Medical Faculty.
- 27 The Medical Faculty of the University of Athens, Greece.

Deaths reported from June 13, 1912 to June 11, 1913.

Admitted.	Name.	Place of Death.	Date of Death.	Age.
1900	Aldrich, Albert Clinton.....	Winchester.....	Jan. 29, 1913	55
1893	Alexander, Clara Jane.....	Mysore, India.....	April 9, 1913	41
1892	Ames, Robert Parker Marr.....	Springfield.....	Jan. 25, 1913	56
1891	Belden, Albert Matson.....	Goschen.....	Aug. 5, 1912	46
1884	Bell, Robert Eddy.....	Lowell.....	Jan. 4, 1913	51
1900	Bolster, Augustus Sargent.....	Worcester.....	Sept. 3, 1912	45
1870	Borden, Henry Francis.....	Brockton.....	Aug. 8, 1912	62
1893	Brett, Frank Wallace.....	South Braintree.....	Aug. 31, 1912	51
1870	Bushee, James Anson.....	Somerville.....	May 23, 1912	75
1875	Cabot, Arthur Tracy.....	Boston.....	Nov. 4, 1912	60
1868	Chase, John Winslow.....	Dedham.....	Jan. 18, 1913	73
1869	Coggin, David.....	Salem.....	May 7, 1913	69
1902	Cohan, Francis Henry.....	Norwich, Conn.....	Feb. 13, 1913	42
1877	Colton, John Jay.....	Lowell.....	Sept. 23, 1912	82
1896	Farrell, George Louis.....	Malden.....	Jan. 1, 1913	46
1892	Fenwick, Joseph Benson.....	Chelsea.....	April 26, 1913	74
1897	Fleming, Anthony.....	Lawrence.....	Nov. 3, 1912	39
1866	Francis, George Ebeneser.....	Worcester.....	Nov. 20, 1912	74
1889	Garceau, Edgar.....	Boston.....	April 29, 1913	47
1887	Harkins, Daniel Stanislaus.....	Dorchester.....	Dec. 8, 1912	48
1906	Holt, Harry Frye.....	Worcester.....	Oct. 19, 1912	35
1894	Ingalls, George Hancock.....	E. Kingston, N.H.....	May 3, 1913	52
1847	Lamb, William Dan.....	Lawrence.....	Aug. 27, 1912	88
1881	Leonard, Henry Fiske.....	Worcester.....	Sept. 25, 1912	53
1906	Long, Merritt Allen.....	Lowell.....	Mar. 4, 1913	37
1898	MacCabe, Arthur.....	Gloucester.....	Nov. 12, 1912	45
1907	MacMonagle, Beverly (Honorary member).....	Paris, France.....	May 22, 1912	58
1906	MacOdum, Angus.....	Cambridge.....	Nov. 23, 1912	47
1880	Magee, John Augustine.....	Lawrence.....	May 23, 1913	65
1883	Mead, Julian Augustus.....	Watertown.....	Mar. 30, 1913	56
1906	Miller, Albert Eber.....	East Orleans.....	April 21, 1913	81
1907	Murphy, James Cornelius.....	Norwood.....	Sept. 3, 1912	30
1909	Nolan, Henry Stuart.....	Roxbury.....	Aug. 18, 1912	28
1883	Porter, Omer Pillsbury.....	Lowell.....	Dec. 7, 1912	55
1898	Record, Wellington.....	Quincy.....	Nov. 11, 1912	59
1876	Richardson, Maurice Howe.....	Boston.....	July 31, 1912	60
1861	Ricketson, Arthur.....	New Bedford.....	Oct. 15, 1912	77
1885	Ring, Allan Mott.....	Arlington Heights.....	June 3, 1913	68
1906	Shanahan, Edward Joseph.....	Taunton.....	June 27, 1912	44
1907	Sparrow, Ernest Harold.....	Cambridge.....	Aug. 27, 1912	32
1870	Stackpole, George Edmund.....	Brookline.....	April 22, 1913	70
1887	Symonds, Benjamin Ropes.....	Salem.....	Oct. 15, 1912	55
1877	Trueworthy, Edwin Weston.....	Lowell.....	Sept. 13, 1912	73
1894	White, Walter Henry.....	Cambridge.....	Nov. 5, 1912	66
1864	Willis, John Warren.....	Waltham.....	Mar. 1, 1913	80
1866	Wood, Albert.....	Worcester.....	Sept. 26, 1912	79

Total 46.

Dr. Homer Gage presented an amended draft of the revised by-laws, and explained that the by-laws had been arranged in chapters and sections with marginal references according to the custom in vogue in this Society previous to the year 1832; that they included all the "special rules" and "standing votes and resolves"; that they fixed the beginning of the fiscal year as

January first; that members in good standing of other State Medical Societies are admitted to fellowship without a written examination; that the duties of all officers and Standing Committees were defined; that four of the Standing Committees had been consolidated into two Standing Committees; that the new by-laws embodied the suggestions of the officers and of many other Fellows of the Society; that a copy had been sent to every Fellow a month before this meeting, and that since then numerous amendments had been incorporated in the revised draft, a copy of which was in the hands of every member present.

On motion by Dr. Goss, 54 members being present, the by-laws were adopted by a unanimous vote,

Voted, That all previous by-laws and standing votes and resolves be, and they hereby are repealed;

Voted, That the digest of the laws relating to the Massachusetts Medical Society, the by-laws, the code of ethics, and the malpractice act be printed in a pamphlet, and that the secretary be directed to have five thousand copies made.

On motion by Dr. R. B. Osgood, it was

Voted, That the thanks of the Society be extended to the Committee of Arrangements for their efficient and successful plans for the meeting.

Papers were read as follows:

1. The Mode of Transmission of Infantile Paralysis. — Dr. Milton J. Rosenau, Brookline, read by Dr. L. W. Hackett.

2. The Treatment of Diabetes Mellitus. — Dr. Elliott P. Joslin, Boston.

3. The Complement Fixation Test in Diagnosis. — Dr. James Homer Wright, Boston.

4. Diagnostic Significance of the Reaction — Local and General — Produced by Intradermic Injections of Dead Gonococci in Gonorrheal Infections. — Dr. W. S. Whittemore, Cambridge, and Dr. G. C. Shattuck, Boston.

5. The Pathological Lesion of Whooping Cough, illustrated by lantern slides. — Dr. Frank B. Mallory, Brookline.

Discussion of Dr. Mallory's paper, by Dr. L. J. Rhea, Boston.

At the close of the papers, a short recess was taken.

At twelve o'clock noon, the annual discourse was delivered by Dr. Homer Gage, of Worcester, with the title: "Some Abuses in Surgical Practice." The attendance at this time was about 200.

On motion by Dr. Lund, the thanks of the Society were tendered to Dr. Gage for his interesting and excellent address.

MEETING OF THE COMBINED MEDICAL AND SURGICAL SECTIONS.

In the afternoon the combined Medical and Surgical Sections held a largely attended meeting at the Boston City Hospital, there being from 260 to 300 members present, where the following papers were read:

Symposium on Diseases of the Gall Bladder.

MEDICAL PAPER. — Condition of the Upper Region of the Abdomen in Relation to Disease of the Gall Bladder. — Dr. Charles G. Stockton, Buffalo, N. Y.

SURGICAL PAPER. — The Errors of Diagnosis in Gall Bladder Disease from a Surgical Point of View. — Dr. John H. Gibbon, Philadelphia, Pa.

Discussion by Dr. G. G. Sears, Boston; Dr. J. T. Bottomley, Boston; Dr. Wilder Tileston, New Haven; Dr. David Cheever and Dr. F. B. Lund, Boston; Dr. H. Gage, Worcester; Dr. J. B. Blake, Boston.

The annual dinner was served in the ballroom of the Copley-Plaza Hotel, in the evening, to 1198 fellows and guests. The President sketched the work of the Society during the year, and introduced the following speakers: — Ex-president Charles W. Eliot, of Harvard University; Robert L. O'Brien, Editor of the *Boston Herald*; Charles G. Stockton, an eminent physician of Buffalo, and John H. Gibbon, a noted surgeon of Philadelphia.

WALTER L. BURRAGE,
Secretary.

Massachusetts Medical Society.

TREASURER'S REPORT.

APRIL 15, 1913.

MR. PRESIDENT and Fellows of the Society, your Treasurer has to report the finances of the Society as follows:

RECEIPTS.

Balance from last year		\$13,700.43
Assessments paid to Treasurer	\$1,088.00	
Assessments paid at Annual Meeting	350.00	
Assessments paid to District Treasurers:		
Barnstable	\$150.00	
Berkshire	355.00	
Bristol North	275.00	
Bristol South	580.00	
Essex North	630.00	
Essex South	820.00	
Franklin	155.00	
Hampden	965.00	
Hampshire	315.00	
Middlesex East	360.00	
Middlesex North	550.00	
Middlesex South	2,155.00	
Norfolk	2,035.00	
Norfolk South	250.00	
Plymouth	415.00	
Suffolk	2,980.00	
Worcester	1,185.00	
Worcester North	375.00	
	<u>\$14,550.00</u>	<u>\$14,550.00</u>
Total assessments	\$15,988.00	\$15,988.00
Premium on foreign check . . . . .		.03
Dinner Tickets	\$8.00	
Interest on Massachusetts Bonds	560.00	
Interest on deposit, Bay State Trust Co.	146.88	
Interest on deposit, New England Trust Co.	191.64	
Interest on deposit, Savings Banks	151.66	
Interest on annuity policies, Mass. Hosp. Life Ins. Co.	842.33	
Renewal of Diploma . . . . .	.50	
	<u>\$31,589.47</u>	<u>\$31,589.47</u>
Total	\$31,589.47	\$31,589.47

EXPENSES.

President:

Stationery		\$8.60
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Secretary:

Etching Seal	\$10.50	
Altering Seal and Elec-		
trotyping	22.00	
Engrossing Diplomas	13.84	
Stenographers at An-		
nual Meeting	50.00	
Stamped envelopes, Pos-		
tals and Printing	72.49	
Addressing programmes	16.00	
Bookbinding	19.50	
Polk's Register	6.00	
Letter File . . . . .	.75	
Boston Med. and Surg.		
Journ., 6 copies . . . . .	.90	
	<hr/>	
	\$211.98	\$211.98

Librarian:

Stamped Envelopes,		
Cards and Stamps	\$158.68	
Printing	3.25	
Delivering in Metropol-		
itan District	134.46	
Envelopes for Commun-		
ications	42.10	
Index Cards	5.50	
	<hr/>	
	\$343.99	\$343.99

Treasurer:

Clerical Work	30.96	
Clerks at Annual Meet-		
ing	60.00	
Postage, Stationery and		
Printing	89.03	
Check Protector . . . . .	.25	
Box at Bay State Trust		
Co.	10.00	
Carriage of Accounts	2.75	
Treasurer's Bond, Am.		
Surety Co.	37.50	
Cards for Catalogue	4.25	
Rubber Stamp . . . . .	.50	
Blank Book . . . . .	.75	
	<hr/>	
	\$235.99	\$235.99

District Treasurers:

Commissions	\$727.75	
Expenses	236.75	
	<hr/>	
	\$964.50	\$964.50
Bank Charges		1.40
Supervisor's Mileage		29.99
Censors		432.00
Shattuck Lecturer		200.00
Cotting Lunch		236.37
Rent		750.00
Salaries		1,700.00
Reversion to Districts		4,000.00
Defense of Malpractice Suits		294.96
Am. Med. Assoc., Expense of Delegates		228.07
Committee on Publications:		
Printing and Binding		3,507.37
Committee on Medical Diplomas:		
Seal on Diploma Plate	26.00	
Printing	10.25	
	<hr/>	
	\$36.25	\$36.25
Committee on By-laws, Printing		20.65
Committee on Membership and Finance, Printing		2.50
Committee on State and National Legislation:		
Stenographers and Typewriters	83.06	
Stamped Envelopes and Cards	14.83	
Printing	81.00	
Typewriting letters	8.25	
Legislative Bulletin	10.00	
Telephone . . . . .	.50	
Incidentals	28.12	
	<hr/>	
	\$225.76	\$225.76
Committee on Tuberculosis:		
Clerical Work, Envelopes, Postage		\$27.75
Committee of Arrangements:		
Printing, Mailing, Postage	\$95.00	
Taxicab . . . . .	.80	
Card Signs	2.25	
Coat Room Checks	1.50	

Badges . . . . .	.60	
Express	4.00	
Janitor at Medical Library	10.00	
Carpenter, Black Board, Cloth, Gas and Elec- tric Appliances	162.37	
Rent of Mechanics Hall	716.00	
Decorations and Palms	85.00	
Music	150.00	
Cigarettes, Cigars, Ginger Ale	190.15	
Caterer	2203.50	
Boston Elevated R.R.	8.65	
Incidentals	5.45	
	<u>\$3635.27</u>	\$3635.27
Committee on Public Health		16.44
Committee on Relations with other State Societies and with the American Medical Association:		
Printing	\$2.50	
Travelling	18.80	
	<u>\$21.30</u>	\$21.30
Return of Overpayment		1.00
Total	\$17,132.14	\$17,132.14
Balance.		<u>\$14,457.43</u>

This balance is distributed as follows:

Deposit in the Bay State Trust Co.	\$7422.41
Deposit in the New England Trust Co.	7004.24
Undrawn interest in the Suffolk Savings Bank	37.85
	<u>\$14,464.50</u>
Deduct outstanding checks	7.07
Balance.	<u>\$14,457.43</u>

The deficit of the previous year has been converted into a surplus of \$757.00. This is accounted for by an increase in collections of \$506.95, and a decrease in expenses of \$1294.93. Of this decrease \$500.00 is due to a smaller reversion to the districts.

PERMANENT INVESTMENTS.

The permanent investments are unchanged and are as follows:

Shattuck Fund:

Annuity Policy of the Mass. Hospital Life Ins. Co.	\$9,166.87
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Phillips Fund:

Massachusetts 3½ Per cent Bonds	10,000.00
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Cotting Fund:

Deposit in Roxbury Institution for Savings . . .	1,000.00
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Deposit in Provident Institution for Savings . .	1,000.00
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Deposit in Suffolk Savings Bank	1,000.00
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Permanent Fund:

Annuity Policy of the Mass. Hospital Life Ins. Co.	11,253.30
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Massachusetts 3½ Per cent Bonds	6,000.00
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Deposit in Franklin Savings Bank	1,074.48
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Total	<u>\$40,494.65</u>
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EDWARD M. BUCKINGHAM,

Treasurer.

Officers of the Massachusetts Medical Society

1913-1914.

CHOSEN JUNE 10, 1913.

WALTER P. BOWERS	Clinton	PRESIDENT
LYMAN A. JONES	North Adams.	VICE-PRESIDENT
WALTER L. BURRAGE	Boston	SECRETARY
EDWARD M. BUCKINGHAM . .	Boston	TREASURER
EDWIN H. BRIGHAM	Brookline . . .	LIBRARIAN

STANDING COMMITTEES.

Of Arrangements.

JOHN HOMANS	BETH VINCENT	W. W. HOWELL
J. D. BARNEY	E. L. YOUNG, Jr.	R. I. LEE

On Publications and Scientific Papers.

G. B. SHATTUCK	E. W. TAYLOR	R. B. OSGOOD
J. S. Stone		F. T. LORD

On Membership and Finance.

F. W. GOSS	C. M. GREEN	A. COOLIDGE
SAMUEL CROWELL		F. W. TAYLOR

On Ethics and Discipline.

J. A. GAGE	J. W. BARTOL	HENRY JACKSON
G. DEN. HOUGH		S. B. WOODWARD

On Medical Education and Medical Diplomas.

H. C. ERNST	H. D. ARNOLD	C. F. PAINTER
H. W. NEWHALL		J. F. BURNHAM

On State and National Legislation.

W. P. BOWERS	C. F. WITHINGTON	F. G. WHEATLEY
G. W. GAY		A. K. STONE

On Public Health.

M. W. RICHARDSON	M. J. ROSENAU	W. I. CLARK
A. L. HAMILTON		E. H. BIGELOW

PRESIDENTS OF DISTRICT SOCIETIES.

VICE-PRESIDENTS (EX-OFFICIO).

(Arranged according to seniority.)

GODFREY RYDER, Malden	Middlesex South
C. E. LOVELL, Whitman	Plymouth
C. E. SIMPSON, Lowell	Middlesex North
HOMER GAGE, Worcester	Worcester
A. B. CUSHMAN, South Dartmouth	Bristol South
F. W. ANTHONY, Haverhill	Essex North
H. D. ARNOLD, Boston	Suffolk
W. F. SAWYER, Fitchburg	Worcester North
W. H. Keleher, Woburn	Middlesex East
W. P. STUTSON, Cummington	Hampshire
C. S. ADAMS, Wollaston	Norfolk South
G. D. WESTON, Springfield	Hampden
J. S. H. LEARD, Jamaica Plain	Norfolk
R. D. DEAN, Taunton	Bristol North
J. B. THOMES, Pittsfield	Berkshire
W. D. KINNEY, Osterville	Barnstable
P. P. MOORE, Gloucester	Essex South
C. F. CANEDY, Greenfield	Franklin

COUNCILORS, 1913-1914.

The initials M.N.C. following the name of a councilor indicate that he is a member of the Nominating Committee.

BARNSTABLE:

J. H. Higgins, M.N.C.	Marstons Mills
C. W. Milliken	Barnstable

BERKSHIRE:

J. F. A. Adams, 114 Wendell Ave	Pittsfield
J. J. Hassett, Main St.	Lee
L. A. Jones, M.N.C., 141 Church St.	North Adams
J. H. Riley, 103 Main St.	North Adams

BRISTOL NORTH:

A. R. Crandell, 48 Church Green	Taunton
F. A. Hubbard, M.N.C., 157 High St.	Taunton
S. D. Presbrey, 103 Weir St.	Taunton

BRISTOL SOUTH:

W. A. Dolan, 546 South Main St.	Fall River
J. H. Gifford, 320 Rock St.	Fall River
G. deN. Hough, 542 County St.	New Bedford

BRISTOL SOUTH: Continued

C. A. Pratt, 60 Orchard St.	New Bedford
A. P. Webber, 250 Union St.	New Bedford
H. G. Wilbur, M.N.C., 292 North Main St.	Fall River

ESSEX NORTH:

R. V. Baketel, Odd Fellows Building	Methuen
J. E. Bryant, 50 Merrimack St.	Haverhill
I. J. Clarke, M.N.C., 112 Emerson St.	Haverhill
E. H. Noyes, 12 Essex St.	Newburyport
F. B. Pierce, 132 Main St.	Haverhill
F. W. Snow, 24 Essex St.	Newburyport
V. A. Reed, 61 Bradford St.	Lawrence
F. E. Sweetsir	Merrimac

ESSEX SOUTH:

H. D. Abbott, 35 High St.	Danvers
G. G. Bailey, Market St.	Ipswich
J. A. Bedard, 26 Ocean St.	Lynn
N. P. Breed, 9 Washington Sq.	Lynn
J. F. Donaldson, 32 Lynde St.	Salem
J. J. Egan, 52 Pleasant St.	Gloucester
M. T. Field, 92½ Essex St.	Salem
A. H. Martin, 29 Broad St.	Lynn
H. L. Paine, Danvers S. Hospital	Hawthorne
H. E. Sears, M.N.C., 25 Broadway	Beverly
J. J. Shea, 14 Bartlett St.	Beverly

FRANKLIN:

G. P. Twitchell, 17½ Federal St.	Greenfield
N. P. Wood, Main St.	Northfield

HAMPDEN:

T. S. Bacon, 69 Maple St.	Springfield
E. A. Bates, 55 Chestnut St.	Springfield
D. J. Brown, 317 Main St.	Springfield
J. M. Birnie, 6 Chestnut St.	Springfield
J. L. Bliss, 231 High St.	Holyoke
C. P. Hooker, M.N.C., 67 Chestnut St.	Springfield
J. C. Hubbard, 243 Maple St.	Holyoke
P. Kilroy, 61 Chestnut St.	Springfield
C. F. Lynch, 217 Main St.	Springfield
S. A. Mahoney, 630 Dwight St.	Holyoke
W. R. Weiser, 97 Chestnut St.	Springfield

HAMPSHIRE:

A. G. Blodgett, 20 Parks St.	Ware
M. W. Pearson, M.N.C., 19 Pleasant St.	Ware
E. D. Williams, 153 Union St.	Easthampton

MIDDLESEX EAST:

D. C. Dennett, M.N.C., 7 Washington St.	Winchester
H. B. Jackson, 96 W. Emerson St.	Melrose
G. N. P. Mead, 27 Church St.	Winchester
E. D. Richmond, 1 Harnden St.	Reading

MIDDLESEX NORTH:

W. G. Eaton, 417 Middlesex St.	Lowell
W. P. Lawler, 53 Central St.	Lowell
G. O. Lavalée, 790 Merrimack St.	Lowell
R. J. Meigs, 226 Merrimack St.	Lowell
A. G. Scoboria	Chelmsford

MIDDLESEX SOUTH:

M. H. Bailey, 1569 Massachusetts Ave.	Cambridge
H. T. Baldwin, 96 Middlesex Road	Chestnut Hill
F. J. Barnes, 67 Brattle St.	Cambridge
F. E. Bateman, 163 Highland Ave.	Somerville
W. A. Bell, 26 Bow St.	Somerville
C. S. Cahill, 311 Prospect St.	Cambridge
J. E. Cleaves, 8 Salem St.	Medford
C. H. Cook, 35 West Central St.	Natick
E. A. Darling, 138 Brattle St.	Cambridge
G. W. Gay	Chestnut Hill
E. G. Hoitt, 12 Howe St.	Marlborough
A. A. Jackson, 512 Broadway	Everett
J. B. Lyons, 1 Dexter Row	Charlestown
S. F. McKeen, 556 Cambridge St.	Allston
C. E. Mongan, 24 Central St.	Somerville
L. M. Palmer, 62 Concord St.	South Framingham
C. E. Prior, 1 Mountain Ave.	Malden
Godfrey Ryder, 321 Pleasant St.	Malden
E. H. Stevens, M.N.C., 1911 Mass. Ave.	Cambridge
Julia Tolman, 695 Mass. Ave.	Arlington
G. T. Tuttle, McLean Hospital	Waverley
H. P. Walcott, 144 State House	Boston
Alfred Worcester, 751 Main St.	Waltham

NORFOLK:

E. F. Bartol, 6 Reedsdale Road	Milton
A. N. Broughton, 10 Roanoke Ave.	Jamaica Plain
G. G. Bulfinch, 526 Harvard St.	Brookline
Samuel Crowell, M.N.C., 8 Monadnock St.	Dorchester
A. H. Davison, 564 Washington St.	Dorchester
F. P. Denny, 111 High St.	Brookline
E. W. Finn, 5 Franklin Square	Dedham
P. J. Fleming, 451 Dudley St.	Roxbury
F. W. Goss, The Warren	Roxbury
T. E. Guild, 1550 Blue Hill Ave.	Mattapan

NORFOLK: *Continued*

W. W. Harvey, 516 Warren St.	Roxbury
A. H. Hodgdon, 110 Maple Place	Dedham
S. A. Houghton, 14 Pleasant St.	Brookline
G. W. Kaan, 419 Boylston St.	Boston
Bradford Kent, 798 Blue Hill Ave.	Dorchester
E. N. Libby, 845 Boylston St.	Boston
C. W. Macdonald, 1 New Heath St.	Roxbury
Charles Malone, 3 Glen Road	Jamaica Plain
W. H. McMann, 328 Center St.	Jamaica Plain
T. J. Murphy, 372 Dudley St.	Roxbury
A. R. Sawyer, 6 Conway St.	Roslindale
A. E. Sherburne, 46 Brent St.	Dorchester
B. E. Sibley, 1595 Beacon St.	Brookline
F. W. Sleeper, 41 Virginia St.	Dorchester
C. F. Stack, 139 West River St.	Hyde Park
J. C. Stedman, 61 Pond St.	Jamaica Plain

NORFOLK SOUTH:

O. H. Howe, Main St.	Cohasset
E. N. Mayberry, M.N.C.	South Weymouth
G. M. Sheahan, 12 School St.	Quincy

PLYMOUTH:

H. F. Copeland, 532 Washington St.	Whitman
Gilman, Osgood, 258 Union St.	Rockland
A. E. Paine, M.N.C., 13 Clinton Ave.	Brockton
F. J. Ripley, 956 Belmont St.	Brockton
F. G. Wheatley	North Abington

SUFFOLK:

H. D. Arnold, 427 Beacon St.	Boston
S. H. Ayer, 318 Shawmut Ave.	Boston
F. G. Balch, 99 Commonwealth Ave.	Boston
J. W. Bartol, 1 Chestnut St.	Boston
J. B. Blake, 161 Beacon St.	Boston
E. G. Brackett, 166 Newbury St.	Boston
E. H. Bradford, 133 Newbury St.	Boston
E. M. Buckingham	Boston
342 Marlborough St.	
W. L. Burrage, 282 Newbury St.	Boston
Hugh Cabot, 87 Marlborough St.	Boston
D. Cheever, 20 Hereford St.	Boston
H. A. Christian, 252 Marlborough St.	Boston
F. J. Cotton, 520 Commonwealth Ave.	Boston
G. A. Craigin, 18 Hereford St.	Boston
W. H. Devine, 595 Broadway	South Boston
J. W. Farlow, 234 Clarendon St.	Boston
R. H. Fitz, 18 Arlington St.	Boston
W. H. Grainger, 408 Meridian St.	East Boston

SUFFOLK: *Continued*

F. B. Harrington, 201 Beacon St.	Boston
J. B. Hawes, 2nd, 295 Beacon St.	Boston
John Homans, 164 Beacon St.	Boston
J. J. Minot, 188 Marlborough St.	Boston
M. W. Richardson, 144 State House	Boston
W. L. Richardson, 225 Commonwealth Ave.	Boston
J. D. K. Sabine, 348 Marlborough St.	Boston
G. G. Sears, 426 Beacon St.	Boston
F. C. Shattuck, M.N.C. 135 Marlborough St.	Boston
G. B. Shattuck, 183 Beacon St.	Boston
A. K. Stone, 44 Fairfield St.	Boston
J. C. White, 259 Marlborough St.	Boston
C. F. Withington, 292 Marlborough St.	Boston
Grace Wolcott, 292 Marlborough St.	Boston

WORCESTER:

W. P. Bowers, 264 Chestnut St.	Clinton
C. A. Church, Elm St.	Millbury
W. J. Delahanty, 5 Trumbull Square	Worcester
J. T. Duggan, 226 Southbridge St.	Worcester
O. H. Everett, 53 Pearl St.	Worcester
Homer Gage, 73 Pearl St.	Worcester
R. W. Greene, 21 West St.	Worcester
David Harrower, M.N.C., 9 Elm St.	Worcester
E. B. Harvey	Westboro
W. G. Reed, Main St.	Southbridge
L. F. Woodward, 52 Pearl St.	Worcester
S. B. Woodward, 58 Pearl St.	Worcester

WORCESTER NORTH:

C. E. Bigelow, 2 Park St.	Leominster
A. E. Mossman	Westminster
E. A. Sawyer, M.N.C., 402 Elm St.	Gardner
J. W. Stimson, 101 Prichard St.	Fitchburg

CENSORS, 1913-1914.

BARNSTABLE:

J. H. Higgins, Supervisor	Marstons Mills
S. F. Haskins	Cotuit
C. E. Harris	Hyannis
E. E. Hawes	Hyannis
E. S. Osborne	West Dennis

BERKSHIRE:

J. F. A. Adams, Supervisor	Pittsfield
William Galvin	Blackinton

BERKSHIRE: *Continued*

G. P. Hunt	Pittsfield
H. B. Holmes	Adams
H. E. Stockwell	Stockbridge

BRISTOL NORTH:

F. A. Hubbard, Supervisor	Taunton
W. Y. Fox	Taunton
D. J. Mehegan	Taunton
T. J. Robinson	Taunton
A. S. Deane	Taunton

BRISTOL SOUTH:

W. A. Dolan, Supervisor	Fall River
C. A. Bonney	New Bedford
W. H. Butler	Fall River
A. I. Connell	Fall River
A. H. Mandell	New Bedford

ESSEX NORTH:

F. B. Pierce, Supervisor	Haverhill
T. R. Healy	Newburyport
J. P. Torrey	Andover
J. J. O'Sullivan	Lawrence
A. N. Little	Newburyport

ESSEX SOUTH:

N. P. Breed, Supervisor	Lynn
H. E. Sears	Beverly
W. V. McDermott	Salem
G. H. Blair	Salem
R. E. Bicknell	Swampscott

FRANKLIN:

G. P. Twitchell, Supervisor	Greenfield
C. L. Upton	Sherburne Falls
C. C. Messer	Turners Falls
E. G. Best	Greenfield
J. W. Cram	Colrain

HAMPDEN:

C. F. Lynch, Supervisor	Springfield
J. P. Schneider	Palmer
D. J. Brown	Springfield
J. L. Bliss	Holyoke
G. H. Janes	Westfield

HAMPSHIRE:

M. W. Pearson, Supervisor	Ware
A. G. Minshall	Northampton
W. J. Collins	Northampton
O. W. Cobb	Easthampton
J. M. Fay	Northampton

MIDDLESEX EAST:

G. N. P. Mead, Supervisor	Winchester
Richard Dutton	Wakefield
H. A. Gale	Winchester
F. R. Sims	Melrose
T. E. Caulfield	Woburn

MIDDLESEX NORTH:

W. G. Eaton, Supervisor	Lowell
J. A. Gage	Lowell
J. V. Meigs	Lowell
J. E. Lamoureaux	Lowell
E. J. Clark	Lowell

MIDDLESEX SOUTH:

H. T. Baldwin, Supervisor	Chestnut Hill
E. H. Bigelow	Framingham
Albert August	Cambridge
J. F. O'Brien	Charlestown
E. S. Abbott	Waverley

NORFOLK:

A. N. Broughton, Supervisor	Jamaica Plain
T. F. Greene	Roxbury
E. P. Starbird	Dorchester
R. W. Hastings	Brookline
W. C. Kite	Milton

NORFOLK SOUTH:

O. H. Howe, Supervisor	Cohasset
D. A. Bruce	Atlantic
F. L. Doucette	East Weymouth
G. D. Bullock	Weymouth
M. E. Drew	Atlantic

PLYMOUTH:

F. J. Ripley, Supervisor	Brockton
C. W. Stodder	Marshfield Hills
Joseph Frame	Rockland
R. B. Rand	North Abington
J. H. Drohan	Brockton

SUFFOLK:

G. A. Craigin, Supervisor	Boston
L. R. G. Crandon	Boston
J. S. Stone	Boston
C. N. Cutler	Chelsea
W. H. Robey, Jr.	Boston

WORCESTER:

R. W. Greene, Supervisor	Worcester
M. J. O'Meara	Worcester

WORCESTER: *Continued*

F. H. Washburn	Holden
C. D. Wheeler	Worcester
A. G. Hurd	Millbury

WORCESTER NORTH:

A. E. Mossman, Supervisor	Westminster
A. P. Lowell	Fitchburg
W. F. Robie	Baldwinsville
A. A. Wheeler	Leominster
B. H. Hopkins	Ayer

COMMISSIONERS OF TRIALS.

1913-1914.

BARNSTABLE	S. H. Sears	Yarmouth Port
BERKSHIRE	A. K. Boom	Adams
BRISTOL NORTH . . .	Elliott Washburn . .	Taunton
BRISTOL SOUTH . . .	J. A. Barré	Fall River
ESSEX NORTH	J. F. Croston	Haverhill
ESSEX SOUTH	J. E. Simpson	Salem
FRANKLIN	F. E. Johnson	Erving
HAMPDEN	G. D. Henderson . . .	Holyoke
HAMPSHIRE	A. G. Blodgett	Ware
MIDDLESEX EAST . . .	A. C. Lane	Woburn
MIDDLESEX NORTH . .	F. E. Varney	North Chelmsford
MIDDLESEX SOUTH . .	E. M. Plummer	Charlestown
NORFOLK	A. H. Hodgdon	Dedham
NORFOLK SOUTH . . .	N. S. Hunting	Quincy
PLYMOUTH	F. J. Hanley	Whitman
SUFFOLK	F. B. Lund	Boston
WORCESTER	E. V. Scribner	Worcester
WORCESTER NORTH . .	F. H. Thompson	Fitchburg

OFFICERS OF THE DISTRICT MEDICAL SOCIETIES.

1913-1914.

- BARNSTABLE. W. D. Kinney, Osterville, President; J. P. Nickerson, West Harwich, Vice-President; P. F. Miller, Harwich, Secretary; H. B. Hart, East Dennis, Treasurer; C. W. Milliken, Barnstable, Librarian.
- BERKSHIRE. J. B. Thomes, Pittsfield, President; F. C. Downing, Lanesboro, Vice-President; O. L. Bartlett, Pittsfield, Secretary; J. D. Howe, Pittsfield, Treasurer.

- BRISTOL NORTH. R. D. Dean, Taunton, President; W. H. Allen, Mansfield, Vice-President; A. R. Crandell, Taunton, Secretary; W. Y. Fox, Taunton, Treasurer; T. F. Clark, Taunton, Librarian.
- BRISTOL SOUTH. A. B. Cushman, South Dartmouth, President; R. W. Jackson, Fall River, Vice-President; A. J. Abbe, Fall River, Secretary; A. J. Abbe, Fall River, Treasurer.
- ESSEX NORTH. F. W. Anthony, Haverhill, President; J. A. Fitz-Hugh, Amesbury, Vice-President; J. F. Burnham, Lawrence, Secretary; J. F. Burnham, Lawrence, Treasurer.
- ESSEX SOUTH. P. P. Moore, Gloucester, President; G. C. Parcher, Saugus, Vice-President; H. P. Bennett, Lynn, Secretary; G. Z. Goodell, Salem, Treasurer; C. M. Cobb, Lynn, Librarian.
- FRANKLIN. C. F. Canedy, Greenfield, President; J. E. Urquhart, Ashfield, Vice-President; W. K. Clark, Greenfield, Secretary; W. K. Clark, Greenfield, Treasurer.
- HAMPDEN. G. D. Weston, Springfield, President; A. L. Cooley, Chicopee Falls, Vice-President; H. L. Smith, Springfield, Secretary; H. L. Smith, Springfield, Treasurer.
- HAMPSHIRE. W. P. Stutson, Cummington, President; E. W. Brown, Northampton, Vice-President; J. D. Collins, Northampton, Secretary; J. G. Hanson, Northampton, Treasurer; F. E. Dow, Northampton, Librarian.
- MIDDLESEX EAST. W. H. Keleher, Woburn, President; C. J. Allen, Winchester, Vice-President; A. E. Small, Melrose, Secretary; Charles Dutton, Wakefield, Treasurer; G. W. Nickerson, Stoneham, Librarian.
- MIDDLESEX NORTH. C. E. Simpson, Lowell, President; T. G. McGannon, Lowell, Vice-President; A. R. Gardner, Lowell, Secretary; T. B. Smith, Lowell, Treasurer; P. J. Meehan, Lowell, Librarian.
- MIDDLESEX SOUTH. Godfrey Ryder, Malden, President; W. D. Swan, Cambridge, Vice-President; L. S. Hapgood, Cambridge, Secretary; C. A. Dennett, Arlington, Treasurer.
- NORFOLK. J. S. H. Leard, Jamaica Plain, President; G. H. Francis, Brookline, Vice-President; Bradford Kent, Dorchester, Secretary; G. W. Kaan, Brookline, Treasurer.
- NORFOLK SOUTH. C. S. Adams, Wollaston, President; F. C. Granger, Randolph, Vice-President; D. B. Reardon, Quincy, Secretary; D. B. Reardon, Quincy, Treasurer; D. B. Reardon, Quincy, Librarian.
- PLYMOUTH. C. E. Lovell, Whitman, President; N. C. King, Campello, Vice-President; A. C. Smith, Brockton, Secretary; A. C. Smith, Brockton, Treasurer.
- SUFFOLK. H. D. Arnold, Boston, President; Paul Thorndike, Boston, Vice-President; W. C. Howe, Boston, Secretary; A. K. Stone, Boston, Treasurer; B. J. Jeffries, Boston, Librarian.

WORCESTER. Homer Gage, Worcester, President; F. H. Clapp, North Grafton, Vice-President; E. L. Hunt, Worcester, Secretary; G. O. Ward, Worcester, Treasurer; Merrick Lincoln, Worcester, Librarian.

WORCESTER NORTH. W. F. Sawyer, Fitchburg, President; H. W. Page, Baldwinsville, Vice-President; C. H. Jennings, Fitchburg, Secretary; F. H. Thompson, Jr., Fitchburg, Treasurer; A. P. Mason, Fitchburg, Librarian.

DELEGATES AND ALTERNATES TO THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION

DELEGATES	ALTERNATES
HUGH CABOT, Boston	J. B. BLAKE, Boston
C. P. HOOKER, Springfield	H. E. SEARS, Beverly
*H. D. ARNOLD, Boston	*L. F. WOODWARD, Worcester
*H. G. STETSON, Greenfield	*A. J. ABBE, Fall River
*H. W. VAN ALLEN, Springfield	G. OSGOOD, Rockland

* Term expires, June 1913.

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**READ THIS SUPPLEMENT FOR THE LIVE
TOPICS NOW BEFORE THE SOCIETY**

Massachusetts Medical Society

SUPPLEMENT

TO

BULLETIN No. 3

NOVEMBER 1, 1913

**MINUTES OF THE OCTOBER MEETING
OF THE COUNCIL, 1913**

OFFICERS AND MEETINGS

OF

District Medical Societies

FOR 1913-1914

**PART OF REPORT OF JUDICIAL COUNCIL OF THE
AMERICAN MEDICAL ASSOCIATION, JUNE, 1913,**

ON

**SECRET DIVISION OF FEES AND
CONTRACT PRACTICE**

THE UNIVERSITY OF CHICAGO
LIBRARY

THE UNIVERSITY OF CHICAGO

LIBRARY

LIBRARY

THE UNIVERSITY OF CHICAGO

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PROCEEDINGS
of the
COUNCIL

October 1, 1913

Massachusetts Medical Society.

PROCEEDINGS OF THE COUNCIL.

OCTOBER 1, 1913.

A STATED MEETING of the Council of the Massachusetts Medical Society was held in the Boston Medical Library, October 1, 1913, at twelve o'clock noon, the President, Dr. W. P. Bowers, in the chair, and the following eighty-eight councilors present:

Barnstable.
C. W. Milliken

Berkshire.
L. A. Jones

Bristol North.
R. D. Dean
F. A. Hubbard
S. D. Presbrey

Bristol South.
W. A. Dolan
J. H. Gifford
H. G. Wilbur

Essex North.
F. W. Anthony
R. V. Baketel
J. E. Bryant
E. H. Noyes
F. W. Snow

Essex South.
J. A. Bedard
J. F. Donaldson
A. H. Martin

Franklin.
G. P. Twitchell

Hampden.
J. M. Birnie

Hampshire.
A. G. Blodgett

Middlesex East.
H. B. Jackson
G. N. P. Mead

Middlesex North.
J. A. Gage

Middlesex North.
W. P. Lawler
C. E. Simpson

Middlesex South.
M. H. Bailey
H. T. Baldwin
F. J. Barnes
F. E. Bateman
J. E. Cleaves
C. H. Cook
E. A. Darling
G. W. Gay
W. H. Keleher
J. B. Lyons
S. F. McKeen
C. E. Mongan

L. M. Palmer
C. E. Prior
Godfrey Ryder
E. H. Stevens
Julia Tolman
G. T. Tuttle
H. P. Walcott
Alfred Worcester

Norfolk.
A. N. Broughton
G. G. Bulfinch
Samuel Crowell
P. J. Fleming
F. W. Goss
T. E. Guild
A. H. Hodgdon
S. A. Houghton
G. W. Kaan
Bradford Kent
J. S. H. Leard
C. W. Macdonald
Charles Malone
F. W. Sleeper

Norfolk South.
C. S. Adams
O. H. Howe
E. N. Mayberry

<i>Plymouth.</i>	F. J. Cotton	<i>Worcester.</i>
Gilman Osgood	W. H. Devine	W. P. Bowers
F. G. Wheatley	W. H. Grainger	W. J. Delahanty
	F. B. Harrington	O. H. Everett
<i>Suffolk.</i>	J. B. Hawes, 2d	Homer Gage
H. D. Arnold	W. L. Richardson	R. W. Greene
S. H. Ayer	J. D. K. Sabine	L. F. Woodward
F. G. Balch	F. C. Shattuck	
J. B. Blake	G. B. Shattuck	<i>Worcester North</i>
E. M. Buckingham	A. K. Stone	A. E. Mossman
W. L. Burrage	C. F. Withington	W. F. Sawyer

The records of the last meeting were read and accepted.

The President announced the recent death of Dr. Edwin B. Harvey, for thirty years a councilor and also an ex-president of the society, and that of Dr. Reginald H. Fitz, for many years a councilor. He then made the following remarks:

"Although the first meeting of our business year occurs in June, so much time is consumed in affairs connected with the annual meeting of the society, the hearing of reports, and the election of officers, that it seems inopportune to suggest topics for discussion, or plans for work, at that time. This second meeting of the year is a more fitting time for suggestions as to changing or enlarging the scope of our activities.

"Last year our President recommended a few plans, some of which have been considered and acted upon. Your attention is again called to the desirability of a consideration of the malpractice act, for if this act is to be continued in force there are certain features which should be carefully studied, such as the question of excluding from the benefits of defence fellows who have insurance with regular companies.

Second: A more exact definition of the kind of suits which are to be defended, i.e., should a fellow evidently negligent be defended, or suits involving blackmail pure and simple.

Third: Should any suits be settled either by the fellows or by the Society.

Fourth: Should medical experts receive any compensation when called as witnesses.

Fifth: Should this subject be under the control of a special committee, as is the case in some state societies. At present it is left to the President and Secretary.

Sixth: Should the fellows of the society be persistently notified of the existence of this protection. At present, the knowledge which we have of this act is not general.

Seventh: Should all fellows, irrespective of their means, be urged to avail themselves of this act.

"These and other questions may properly be considered by a committee and a report made at a subsequent meeting.

"The question has been raised as to the responsibility of our society relating to the appointment of medical men to public office. There is in process of formation an unofficial voluntary committee which will endeavor to work for good appointments; but you should consider whether it would not be wise to have an addition to the list of regular committees which will have official responsibility along this line.

"A very important suggestion relating to the development of regular publications of the activities of the society has been made. This is a subject of great interest and might be of value. You should study the problem and come to some definite conclusion in the near future.

"Your president has become more familiar with the work done by your Secretary and Treasurer, and is of the opinion that these officers are not receiving the compensation to which they are entitled. These matters have not been considered by the council for several years, and should be reviewed and acted upon.

"Your responsibility for the standing and fitness of your members is great, and regular concerted efforts should be made to keep the average doctor up to the requirements of modern practice. And not only physicians, but the public, should be systematically instructed in those matters which they are able to assimilate and use in the promotion of health and the prevention of disease. A campaign of this sort should not be desultory or spasmodic, but rather a concerted movement, arranged for and planned out by men in this society who know best what is needed and how that want can be supplied. At the earliest possible time you, as the executive body of the society, should take this matter in charge.

"Because of the necessity of a larger income, the question of the expense of the annual dinner is important. Many states require the participants to pay a part, or even the whole cost, of this entertainment; and with us, even a partial payment of this outlay would relieve the society of a serious burden and enable us to develop actively along the lines suggested above."

The Committee on Membership and Finance reported through Dr. Goss as follows:

The Committee on Membership and Finance reports and respectfully recommends that these fellows be allowed to change their district membership without a change of legal residence.

D. Harold Walker from Norfolk to Suffolk
George W. Morse from Worcester to Suffolk

Also, that the resignations of the following be accepted:

George R. Callender, U. S. Army
Helen B. Carpenter, Seattle, Wash.
Alden V. Cooper, Hinesburg, Vt.
Robert K. B. Knowles, Entwistle, Alberta, Can.

Eliza B. L. Norton, Norwood
Charles S. Wright, Portland, Me.

Also, that the following be placed on the retired list:

Albert D. Kingsbury, Needham
Alfred W. La Vigne, Lowell
William H. Wescott, Roxbury

Also, that the following be deprived of the privileges of fellowship for non-payment of dues:

Joseph L. Ameno, New York, N. Y.
Freeman D. Bosworth, Jr., Richmond, Va.
Thomas J. Brennan, Little Compton, R. I.
Orestes M. Brown, Everett
Adelbert A. Bryson, Roxbury
Homer A. Bushnell, North Adams
Nelson C. Davis, Dorchester
George W. Derrick, Norwood
Richard A. Drake, West Medford
Marland H. Eaton, Beverly
George C. Gates, Chicopee
Howard A. Gibbs, Attleborough
William P. Grovestein, North Scituate
William A. Hare, Springfield
Frank P. Hudnut, Brookline
James H. Joyce, Salem
George F. Keenan, Boston
Joseph E. Lanoie, Montreal, Can.
Harold K. Marshall, Manila, P. I.
James H. McCann, South Framingham
John S. McCormack, Jamaica Plain
Carl E. Meyer, Chicopee
George C. Moore, Boston
Vernon H. C. Morse, Avon, Conn.
Edward E. Myers, New York, N. Y.
Alden R. Newhall, Holliston
James A. O'Reilly, St. Louis, Mo.
Frederic J. Peirce, Atlantic
William H. Raymenton, Worcester
George E. Reynolds, Pittsfield
Carl W. Rosenbloom, Holyoke
Henry C. B. Snow, Buzzards Bay
William L. Thompson, Boston
Edwin C. Thorn, Deerfield
Willis L. Tucker, Hinsdale
Horace G. Webber, Wilbraham
Frank B. Worthing, Chatham
Frederic J. Wurtele, Denver, Colo.

On amendment by two councilors, the names of Richard A. Drake of West Medford, and E. C. Thorn of Deerfield were removed from the list of those to be deprived of the privileges of fellowship.

Voted, To accept the report and adopt its recommendations as amended.

The reports of the committees appointed to consider the petitions of J. D. Clark, O. R. Fountain, J. W. McKoan, J. H. Costello and M. Gerstein, to be restored to the privileges of fellowship, were acted upon favorably; and the report of the committee appointed to consider the petition of W. H. Davis (namely, that it could not consider the petition in the form in which it was written) was accepted.

The resignation of Dr. H. D. Arnold as a member of the committee on medical education and medical diplomas was accepted with regret. On nomination by the president, Dr. Channing Frothingham, Jr., was appointed a member of this committee in place of Dr. Arnold.

On nomination by the president, Drs. Vanderpoel Adriance, of Williamstown, and W. O. Wilder, of Pittsfield, were appointed delegates to the annual meeting of the Vermont State Medical Society.

Dr. Homer Gage reported progress for the committee on the revision of the boundary line between the Suffolk and the Norfolk Districts, and asked that the committee be continued; and it was so voted.

Dr. H. D. Arnold reported for the delegates of the Massachusetts Medical Society to the House of Delegates of the American Medical Association. The following topics were considered:

Credentials of delegates; Membership and fellowship; Uniform regulation of membership; Relation of the A.M.A. to constituent State associations in matters of health and public instruction; National department of health; Medical education; The secret splitting of fees and "contract" practice; Sections; New section on Gastro-enterology and Proctology; Elections; Next meeting place; Delegates to the A.M.A. Dr. Arnold concluded his report as follows:

"For six consecutive years I have had the honor of acting as a delegate of the Massachusetts Medical Society to the A.M.A., and I have attended all the meetings of the House of Delegates during that period. In relinquishing this position, I wish to express my appreciation of the honor thus conferred, not only by re-election for this period, but by the favorable action of this society on all the essential recommendations which have been made from time to time in connection with this service. I trust

you will pardon me if I add a few comments and suggestions based on this experience.

"At the beginning of this service, Massachusetts counted for little in the councils of the A.M.A. and in the important movements which the association was undertaking. These movements were for the benefit of the public and the profession, and Massachusetts should have been one of the leaders. This state of affairs was due in part to apathy on the part of our society as to its relations to the A.M.A., but chiefly to a lack of appreciation of the importance of the position of delegate, of the importance of having a full representation in the House of Delegates, and of having delegates serve terms long enough for them to become familiar with the machinery of the business organization. In a previous communication to the council, I pointed out that usually there had been an attendance of only two or three delegates, although the society was entitled to six, and that a man rarely attended even two years in succession. A man needs time to learn how the business is conducted, to become acquainted with the men who are working for the benefit of the profession, and to become known by them. Until this is accomplished, he can do little in the way of accomplishment, and his state society can have little influence.

"All this is now changed. I wish little credit for it personally — only for a willingness to devote a certain amount of time and energy to these matters when I would have preferred to attend scientific or social occasions. We have had loyal co-operation by all the Massachusetts delegates. They have stood together for the ideals that the Massachusetts Medical Society stands for, and they have been heard from in some of the controversies. The association now knows that Massachusetts is an important factor and that it is always to be found on the side of what is right.

"From my report of the action of the House of Delegates, it must be clear to all that that body has to deal with many questions in which the society is vitally interested. Our society wishes to do its share in these important movements. It must also be ready to protect its own interests. For both these reasons there should always be a full delegation. In addition, delegates should be chosen who are able and willing to take part in the work of deliberation and administration, and at least two of the men should be serving terms of at least four years. It is important always to have present at least one man who has served at least two years and who is familiar with the situation. The medical profession is not free from self-seekers. The large influence of the association and its accumulating funds are an attraction to those who seek power for their own selfish aims. Politicians, in the real sense of the word, are developed. The experience of the past few years has shown that a few such men could, by skilful combination of effort, gain control of the association if the better elements — a very large majority — do not maintain a watchful organization.

These same years have shown also that these better elements, if organized, can pull the association out of perilous situations. The danger will return, however, and Massachusetts should adopt a permanent policy that will aid in making the association what it should be — a representative body of the whole medical profession of the country."

Voted, To accept the report and place it on file.

Dr. Gay moved and it was voted that the cordial thanks of the Society be extended to Dr. Arnold for his efficient service as a delegate to the A.M.A.

On motion by Dr. Arnold, the following votes were passed:

Voted, That the Secretary be instructed to send to each member of the Society a copy of that part of the report of the Judicial Council of the American Medical Association which refers to secret fee splitting and "contract" practice.

Voted, That a committee be appointed to consider the relations of the Massachusetts Medical Society to the American Medical Association and to other state societies, and that it make a report to the council at its annual meeting.

This committee shall consist of the following officers: The President, Vice-president, Secretary, Treasurer, and the following to be chosen by the President: One member of the committee on membership and finance, two presidents of district societies, two secretaries of district societies, two of the delegates to the American Medical Association who attended the last meeting of the House of Delegates.

Dr. George W. Gay introduced the following preambles and resolutions, which were passed unanimously:

Whereas: Dr. Edwin Bayard Harvey, one of the oldest members of the Massachusetts Medical Society, has recently passed away, and

Whereas: He was for nearly half a century an active and loyal member of the society, always interested in its welfare, at one time its president and for more than thirty years a councilor, and

Whereas: He was the originator of and sponsor for the bill establishing the present Board of Registration in Medicine in this state and for seventeen years its efficient secretary; also the father of the bill which supplies free text-books to the pupils of the public schools of the state, and

Whereas: He has rendered valuable service to the public and to the profession upon many occasions in shaping and guiding wise legislation, as well as in opposing pernicious legislation; now, therefore, be it

Resolved: By the council of the Massachusetts Medical Society in session assembled, that it is deeply sensible of Dr. Harvey's

many excellent qualities, as well as of the valuable services rendered the public and the profession during a long and active life.

Resolved: That in the opinion of this council, Dr. Harvey's death is a distinct loss to the Commonwealth, which he has served so faithfully, and to the profession, to which he has been loyal, and which has now been deprived of his sound judgment and wise counsel.

Resolved: That the secretary be directed to send a copy of these resolutions to Mrs. Harvey and also to the *Boston Medical and Surgical Journal* for publication.

Dr. Withington raised the question of the compensations of the secretary and treasurer of the society, stating that in his opinion they were inadequate for the time and effort expended. He moved, and it was

Voted, That the committee on membership and finance be requested to consider the subject of the salaries of the secretary and treasurer and report at a subsequent meeting of the council.

Dr. Cotton spoke for the committee of the Society on the Workmen's Compensation Act, and introduced the following motion:

Moved, That the president be empowered to direct the legal counsel of the Society to bring before the Superior Court, and if need be the Supreme Court, a test case under Part III, Sections 11 and 16, of the Workmen's Compensation Act (Chapter 751, Acts of 1911, as amended by Chapters 172 and 571, Acts of 1912) in order to clear up in part the vexed matter of the ultimate payment of physicians' fees in disputed cases.

The motion was discussed by Drs. Cotton, Cook and Dolan, and was passed.

Dr. Ryder discussed the question of the present working of the Society's Act for the Defence of Malpractice Suits. He read the following statement of the cases of malpractice which has been placed in the hands of the attorney for the Massachusetts Medical Society from June 10, 1908, when the Act went into effect, to October 1, 1913, fourteen cases in all.

Disposal of these cases:

Settled	4 cases
Verdict for defendant	2 cases
Suit withdrawn	3 cases
No suit brought	2 cases
Insurance Co. forced by our attorney to defend suit	1 case
Pending	2 cases

Total 14 cases

Total cost of malpractice defense to date \$1926.00
Average cost per year \$385.00

In addition to these fourteen cases, the secretary has discussed malpractice defence cases and furnished application blanks and copies of the act to approximately sixty (60) fellows during the time the act has been operative.

Dr. Ryder read seven suggestions which had been advanced for the perfecting of the Malpractice Act and to make it of greater use to the largest number of fellows.

He moved, and it was

Voted, That a committee be appointed by the president to consider the working of the Malpractice Act and to report at a subsequent meeting of the council what changes in the act, if any, are advisable. The president appointed the following committee: Godfrey Ryder, G. W. Gay, F. W. Goss, Hugh Cabot, A. N. Broughton.

Dr. Homer Gage spoke of the matter of publications. He said that the society often failed to get information about matters of general interest to the members promptly and the question had arisen as to how to meet this difficulty satisfactorily. Three suggestions had been made:

1. That a special department devoted to the affairs of the society should be created in the *Boston Medical and Surgical Journal*, and that every member of the society should receive a copy of the *Journal*.

2. That the society should take over the *Boston Medical and Surgical Journal*. And

3. That the present quarterly publication published by the society should be developed along larger lines so that more frequent numbers should be issued.

Dr. Gage moved, and it was

Voted, That the question be referred to the committee on publications and scientific papers, with a request that a report from this committee be given at the next meeting of the council.

On motion by Dr. L. M. Palmer, it was

Voted, That the president appoint a committee of five to draw up resolutions on the death of Reginald Heber Fitz.

Adjourned at 1.20 P.M.

WALTER L. BURRAGE,
Secretary.

OFFICERS AND MEETINGS
of
District Medical Societies
for
1913-1914

BARNSTABLE DISTRICT MEDICAL SOCIETY.

President, W. D. Kinney, Osterville.

Secretary, P. F. Miller, Harwich.

Quarterly Meeting. August 14, 1913. At Marton's Mills.
12 noon.

Dr. M. B. Swift, Fall River, Acute Retention of Urine
of Prostatic Causation. Observations from fifty-two
cases.

Quarterly Meeting. November 13, 1913, at hotel in Sandwich.
12 noon.

Quarterly Meeting. February 12, 1914, at hotel in Hyannis.
12 noon.

Annual Meeting. May 14, 1914, at Barnstable Inn, Barn-
stable. 12 noon.

BERKSHIRE DISTRICT MEDICAL SOCIETY.

President, J. B. Thomes, 86 North St., Pittsfield.

Secretary, O. L. Bartlett, 73 North Street, Pittsfield.

Meetings will be held at Pittsfield, North Adams, Lee or
Great Barrington at 2 P.M.

October 30, 1913, at North Adams.

December 26, 1913.

February 26, 1914.

April 30, 1914. Annual meeting.

BRISTOL NORTH DISTRICT MEDICAL SOCIETY.

President, R. D. Dean, 81 Main St., Taunton.

Secretary, A. R. Crandell, 48 Church Green, Taunton.

September 18, 1913, at the Lowney Tavern, Mansfield,
1.30 P.M. Hematuria by Dr. C. G. Mixter, Boston.

April 16, 1914. Annual meeting, at Taunton.

BRISTOL SOUTH DISTRICT MEDICAL SOCIETY.

President, A. B. Cushman, South Dartmouth.

Secretary, A. J. Abbe, 375 Rock St., Fall River.

Meetings will be held at 5 P.M.

Nov. 13, 1913, Chamber of Commerce Building, Fall
River. *Papers:* Vaccination, Dr. Edward F. Cody, New
Bedford. Symposium on Tuberculosis; Early diag-
nosis, Dr. John B. Hawes, 2d, Boston. Sanatorium
treatment, Dr. Sumner Coolidge, Lakeville; Joints and
spine, Dr. W. R. MacAusland, Boston; Discussion
opened by Dr. A. S. MacKnight, Fall River.

May 14, 1914, Annual meeting, Chamber of Commerce Building at Fall River. (Committee on program will be appointed on Nov. 13, 1913.)

ESSEX NORTH DISTRICT MEDICAL SOCIETY.

President, F. W. Anthony, 50 Merrimack St., Haverhill.
Secretary, J. F. Burnham, 99 Bradford St., Lawrence.

Meetings. Quarterly meeting, October 8, 1913, Wolfe Tavern, Newburyport, at 2.00 o'clock. *Papers*: Abduction method of treatment in fractures at the neck of the femur, Dr. J. E. Goldthwait, Boston. Special points in the treatment of hip fractures; illustrated with lantern slides, Dr. F. J. Cotton, Boston.

January 7, 1914, *Semi-annual meeting*, at Haverhill, at 12.00 o'clock. *Clinical Meeting*. Action will be taken upon a communication from the Industrial Accident Board recommending methods for the proper administering of the medical details of the Workmen's Compensation Act and upon a communication from the A.M.A. asking for the methodical coöperation of the society with the American Red Cross.

May 6, 1914. *Annual Meeting*, at Lawrence, at 12.00 o'clock.

ESSEX SOUTH DISTRICT MEDICAL SOCIETY.

President, P. P. Moore, 58 Middle St., Gloucester.
Secretary, H. P. Bennett, 41 Lewis St., Lynn.

Meetings will be held at 6.30 p.m.,
 November 4, 1913, at Cape Ann Camera Club, Gloucester. *Paper* by Dr. J. B. Hawes, 2d, Boston, Tuberculosis, early diagnosis and treatment.
 December 16, 1913, at Hotel Seymour, Lynn. *Paper*: Sterility, Dr. Edward Reynolds, Boston.
 January 27, 1914, at Essex House, Salem.
 March 17, 1914, at Cape Ann Camera Club, Gloucester.
 May 12, 1914, Annual meeting at Relay House, Nahant.

FRANKLIN DISTRICT MEDICAL SOCIETY.

President, C. F. Canedy, 60 Bridge St., Shelburne Falls.
Secretary, W. K. Clark, 6 Franklin St., Greenfield.

Meetings will be held at the Mansion House, Greenfield at 11.15 A. M.,
 November 11, 1913.
 January 13, 1914.

March 10, 1914.

May 12, 1914. Annual meeting.

(The secretary writes that the readers have not yet been selected.)

HAMPDEN DISTRICT MEDICAL SOCIETY.

President, G. D. Weston, 70 Main St., Springfield.

Secretary, H. L. Smith, 249 Union St., Springfield.

Meetings will be held at Cooley's Hotel, Springfield, at 4.00 P.M.

October 21, 1913. *Papers*: Clinical Aspects of spinal cord injuries, Dr. Philip Kilroy. Surgery of spinal cord injuries, Dr. F. B. Sweet. Discussion by Drs. S. A. Mahoney, G. D. Henderson and W. R. Weiser. Dinner at 6.00 P.M.

Jan. 20, 1914. Program to be announced.

April 21, 1914. Program to be announced. Annual Meeting.

HAMPSHIRE DISTRICT MEDICAL SOCIETY.

President, W. P. Stutson, Cummington.

Secretary, J. D. Collins, 90 Main St., Northampton.

Meetings will be held in the Medical Room of the Forbes Library, Northampton, at 11.30 A.M. as follows:

September 10, 1913.

November 13, 1913.

January 14, 1914.

March 11, 1914.

May 14, 1914.

(The secretary writes that the readers are selected one month before the meeting.)

MIDDLESEX EAST DISTRICT MEDICAL SOCIETY.

President, W. H. Keleher, 48 Pleasant St., Woburn.

Secretary, A. E. Small, 90 West Emerson St., Melrose.

Meetings will be held at the American House, Boston, at 6.30 P.M.,

October 16, 1913. Mr. James B. Carroll, Chairman, Industrial Accident Board.

November 19, 1913. Dr. L. R. G. Crandon. Surgical Dressing.

December 17, 1913. Dr. John Lovett Morse. (Subject to be announced later.)

January 21, 1914. Dr. Herbert B. Howard, Superintendent, Peter Bent Brigham Hospital.

February 18, 1914. Dr. Fred B. Lund. (Subject announced later.)

March 18, 1914.

April 15, 1914.

May 13, 1914. Annual meeting.

MIDDLESEX NORTH DISTRICT MEDICAL SOCIETY.

President, C. E. Simpson, 9 Central St., Lowell.

Secretary, A. R. Gardner, 64 Central St., Lowell.

Meetings.

July 30, 1913.

October 29, 1913, at 6 P.M., at the New American Hotel, Lowell.

January 28, 1914, same time and place.

April 29, 1914, Annual meeting, same time and place.

MIDDLESEX SOUTH DISTRICT MEDICAL SOCIETY.

President, Godfrey Ryder, 321 Pleasant St., Malden.

Secretary, L. S. Hapgood, 6 Garden St., Cambridge.

Meetings.

Oct. 8, 1913, Semiannual meeting, Boston Medical Library, 8 The Fenway, Boston, at 12 o'clock noon.

Discussion. The Boston Medical and Surgical Journal.

Papers. Etiological factors in the chronic arthritides, Dr. E. G. Brackett, Boston. Orthopedics for the general practitioner, Dr. J. W. Sever, Cambridge.

December 11, 1913. Special meeting. Boston Medical Library. 12 o'clock noon. "Pitfalls in obstetrics," Dr. Howard T. Swain, Boston. "Maternity in relation to public health," Dr. C. E. Prior, Malden.

January 14, 1914. Regular Mid-winter meeting. Boston Medical Library. 12 o'clock noon. Dr. David L. Edsall, Boston. Subject to be announced. "Duties of members to the State Society," Dr. Walter P. Bowers, Clinton.

March 12, 1914. Special meeting. Boston Medical Library. 12 o'clock noon. "Syphilis in general practice," Dr. R. C. Cabot, Boston. "Salvarsan Treatment," by one of our members.

April 15, 1914. Annual meeting. American House, Boston. 11 o'clock A.M. Business meeting at 11, Annual Address at noon, Dinner at 1. Dr. Charles D. McCarthy of Malden, orator. Subject of address to be announced later.

NORFOLK DISTRICT MEDICAL SOCIETY.

President, J. S. H. Leard, 392 Arborway, Jamaica Plain.
Secretary, Bradford Kent, 798 Blue Hill Ave., Dorchester.

All Meetings except Annual meeting, will be held at 8.00 P.M.
at Roxbury Masonic Temple, 171 Warren St.

Oct. 28, 1913. Subject — Children.

Communications. "Suggestive Treatment in the Diseases
of Childhood." Dr. William W. Howell.

Discussion by Drs. Edward W. Taylor, and Charles D.
Knowlton,

Refreshments after the meeting.

Nov. 25, 1913. Subject — Medicolegal work in Boston.

Dec. 30, 1913. Subject — Cancer.

Jan. 27, 1914. Subject — Insurance work from the phy-
sician's standpoint.

Feb. 24, 1914. Subject — The Bertillion System.

Mar. 31, 1914. (Subject open.)

May 11, 1914. Annual meeting (place to be announced
later).

NORFOLK SOUTH DISTRICT MEDICAL SOCIETY.

President, C. S. Adams, 62 Brooks St., Wollaston.
Secretary, D. B. Reardon, 22 School St., Quincy.

Meetings will be held at the United States Hotel, Boston, at
11.30 A.M.

Oct. 2, 1913,

Nov. 6, 1913.

Dec. 4, 1913.

Jan. 1, 1914.

Feb. 5, 1914.

Mar. 5, 1914.

Apr. 2, 1914.

May 7, 1914. Annual meeting.

PLYMOUTH DISTRICT MEDICAL SOCIETY.

President, C. E. Lovell, South Ave., Whitman.
Secretary, A. C. Smith, 7 Main St., Brockton.

Meetings are held usually at the Commercial Club, Brockton,
at 11 A.M.

July 17, 1913.

Oct. 16, 1913.

Jan. 15, 1914.

April 16, 1914. Brockton. Annual meeting.

SUFFOLK DISTRICT MEDICAL SOCIETY.

President, H. D. Arnold, 427 Beacon St., Boston.

Secretary, W. C. Howe, 303 Beacon St., Boston.

All meetings will be held at the Boston Medical Library, 8 The Fenway, at 8.15 P.M., in conjunction with the meetings of the Boston Medical Library.

October 25, 1913. Stated Meeting of the Suffolk District Medical Society. "The Harvard Expedition to South America." Illustrated. Dr. Richard P. Strong, Prof. of Tropical Medicine.

November 19. "The Ileo-Colic Valve." Dr. Edward Martin, Philadelphia.

December 3. "Isolation and Care of Contagious Diseases in the Hospital and in the Home." Dr. Charles V. Chapin, Supt. of Health, Providence, R. I.

December 17. "Recent Advances in the treatment of Syphilis of the Nervous System." Drs. Lesley H. Spooner, and James B. Ayer.

January 7, 1914. "The Value of Fascial Transplantation in Surgery, an Experimental and Clinical Study." With lantern slides. Dr. Dean Lewis, Chicago.

January 21. Medical Meeting. Subject to be announced.

February 4. "Surgery of the Peripheral Nerves." Dr. C. A. Porter.

February 18. Paper by Dr. E. C. Rosenow, Chicago. Subject to be announced.

March 4. "Symposium on Pneumonia." Speakers to be announced.

March 18. "Cerebral Tumors." Dr. E. H. Nichols.

April 1. "Psychotherapy." Speakers to be announced.

April 25. Annual Meeting of the Suffolk District Medical Society. "Recent Developments in the Treatment of Fractures." Dr. Frederick J. Cotton.

WORCESTER DISTRICT MEDICAL SOCIETY.

President, Homer Gage, 72 Pearl St., Worcester.

Secretary, E. L. Hunt, 771 Main St., Worcester.

Meetings will be held in G.A.R. Hall, Worcester at 4 P.M.

Oct. 8, 1913. The X-ray diagnosis of diseases of upper right and lower left quadrants of the abdomen, Dr. Ariel W. George, Boston. Paper by Dr. H. W. Van Allen, Springfield. Paper by Dr. Frank W. George, Worcester. Exhibition of skiagrams by the above and Drs. P. H. Cook and A. E. O'Connell of Worcester.

Nov. 12, 1913. Subject—Syphilis. Diagnosis of Obscure Lesions. Dr. J. H. Cunningham, Jr., Boston. Serum

- Reactions. Dr. R. Kinnicutt, Worcester. Treatment, Based on Experience in 300 Cases. Dr. O. D. Phelps, Worcester.
- Dec. 10, 1913. Surgical Meeting. Subject to be announced. Dr. Howard Lillenthal, New York.
- Jan. 14, 1914. To be arranged by Dr. M. F. Fallon of Worcester.
- Feb. 11, 1914.
- Mar. 11, 1914.
- Apr. 8, 1914. (Subject to be announced.)
- May 13, 1914. Annual Meeting.
- Orator, Dr. F. H. Baker, Worcester.

In addition to the regular meetings of the Society it is planned to have a series of four free public lectures on subjects relating to Hygiene and Public Health. These are to be arranged by a special committee, authorized at the October meeting.

WORCESTER NORTH DISTRICT MEDICAL SOCIETY.

President, W. F. Sawyer, 67 Prichard St., Fitchburg.

Secretary, C. H. Jennings, 42 Fox St., Fitchburg.

Meetings will be held in Lincoln Hall, at Fitchburg, at 1.30 p.m., July 29, 1913.

Oct. 28, 1913, Observations at the International Congress of Medicine at London, Dr. A. F. Roderick. Recent advances in Roentgenology, Dr. C. H. Jennings. Report of Cases, Dr. B. W. Carey.

Jan. 27, 1914.

April 28, 1914.

The secretary writes that the programs are arranged between meetings.

THE NEXT ANNUAL MEETING OF THE MASSACHUSETTS MEDICAL SOCIETY WILL BE HELD IN BOSTON, TUESDAY AND WEDNESDAY, JUNE 9-10, 1914.

THE NEXT ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION WILL BE HELD IN ATLANTIC CITY, JUNE 1-5, 1914.

PART OF THE REPORT
OF THE JUDICIAL COUNCIL OF THE
AMERICAN MEDICAL ASSOCIATION,
JUNE, 1913, ON
SECRET DIVISION OF FEES AND
CONTRACT PRACTICE

PART OF THE REPORT OF THE JUDICIAL COUNCIL
OF THE
American Medical Association

JUNE, 1913, ON

SECRET DIVISION OF FEES AND
CONTRACT PRACTICE

The Judicial Council desires to make the following report concerning its investigation on the matter of secret division of fees, the giving of commissions and the matter of contract practice.

The Judicial Council in endeavoring to obtain information on these subjects believed that it was acting as an impersonal body to obtain information for the members of the American Medical Association as to the prevalence of these practices throughout the United States and the relative prevalence in each state and section of the country, and while gathering this information it desired also to obtain the opinions of the different members scattered in various sections regarding the apparent cause of these practices and also an expression of opinion from those who justified the practice and from those who condemned it. It was necessary, therefore, to send out some standard circular in which uniform questions could be asked that answers could be obtained from which uniform standards of judgment could be made. It was further evident that an impersonal investigation should not ask specific names and instances. The detective point of view of seeking guilt should not be the motive which prompted this investigation, but that of an impersonal, fair-minded seeker after knowledge. To obtain these ends the following circular was sent:

Dear Doctor: — The House of Delegates of the American Medical Association at the Atlantic City meeting held June, 1912, instructed the Judicial Council to investigate and report next June on the secret division of fees, taking of commissions, and contract practice. In compliance with these instructions, the Judicial Council is asking certain prominent members of the profession in all the states of the Union to answer the accompanying questionnaire. Your name will not be used or referred to as the source of any information you may give. While the citing of specific instances may seem wise to you, the Council at this time does not desire to make use of definite individual cases but wishes rather

to obtain a general knowledge of the existence of these practices in the various communities in the different states and to estimate as accurately as possible the economic and social cause for these practices. The number which appears on the form for reply indicates the locality from which the reply is obtained, so that it will not be necessary for you to sign this information blank. The Judicial Council will greatly appreciate your coöperation if you will fill out the blank and return it in the enclosed stamped envelope to the Secretary of the Council, 535 Dearborn Avenue, Chicago.

Very truly yours,

ALEXANDER LAMBERT, Chairman.
A. B. COOKE,
JAMES E. MOORE,
HUBERT WORK,
GEORGE W. GUTHRIE,
ALEXANDER R. CRAIG, Secretary.

1. How prevalent is the secret division of fees (i.e., without the full knowledge of the patient) in your community?

2. Are you practicing one of the specialties? If so, what?

How often have you been asked during the year 1912 by those referring patients to you to divide the fee, or grant a commission?

How often have you been offered part of the fee or a commission for referring cases?

In how many instances was the patient acquainted with the terms according to which the division was to be made?

Can a secret division of fees or the granting of commissions be justified? If so, on what grounds?

3. In your locality, do the hospitals or sanitariums offer commissions for the reference of patients?

Do pharmacists offer or give commissions? Do houses furnishing medical or surgical supplies or appliances offer or give commissions?

Do you know of instances of physicians demanding any of the above commissions?

How prevalent is this practice?

4. What form of contract practice, if any, exists in your community?

(Kindly use the following division in answering this question, and give the terms of the usual contract so far as known, stating both the service required and the return made.)

- (a) Mines.
- (b) Factories.
- (c) Railroads.
- (d) Lodges.
- (e) Municipal.

5. What is (a) the cause and what (b) the effect on the profession of the secret division of fees?

Of taking or demanding commissions?

What economic or social conditions account for the contract practice that exists:

- (a) Mines.
- (b) Factories.
- (c) Railroads.
- (d) Lodges.
- (e) Municipal.

6. Are your answers to these questions based on personal knowledge or rumor?

A circular was sent to each president and to each secretary of each county society in every state in the United States, and the various sections of the country were further apportioned off to the members of the Judicial Council who sent throughout their sections personal letters containing these circulars to various members of the profession whom the members of the Judicial Council knew to be prominent in their sections and who would be conversant with the public opinion and the practices of the various members of the profession in their communities. Some six thousand circulars were thus sent out and the replies received amounted to just over 50 per cent of the circulars sent. Thus, considering the membership of the American Medical Association as seventy thousand, about 8 per cent have been circularized and the report made is based on the answers and the knowledge obtained from some 4 per cent of the total membership. This is approximately the same proportion of the American Medical Association which is usually present at the annual meetings and is equivalent to a reply from half that number.

The report may be further said to be based on the opinion of those officially representing the ultimate constituent bodies of the American Medical Association in the various states together with the pick of the prominent and active members selected in each state.

It may be justly said, therefore, to be a report founded on the representative opinion of the members of the American Medical Association.

From the statistics thus gathered it is evident that in the matter of secret splitting of fees, while the existence of the practice cannot be denied in any state, the degree of its prevalence varies greatly in different sections of the United States and the opinion of the local profession for or against it also varies in different regions. In the New England states — Maine, New Hampshire, Vermont, Massachusetts, Connecticut and Rhode Island — the practice is not prevalent though it exists to a slight degree in them all, being most prevalent in and towards the larger cities of Massachusetts and in that part of Connecticut that is near New York. In New York state the practice varies, some counties being nearly free of it, other counties and the large cities being filled with it.

In New York City with its crowded population and with its large proportion of foreigners, in some sections of the city, among certain groups of men, it is without doubt the rule rather than the exception and this is true in spite of the increasingly strong opinion in the profession as a whole against the practice. In Pennsylvania it is a little less prevalent than in New York. New Jersey, Delaware, District of Columbia, Maryland, Virginia and West Virginia show a strong sentiment against it and not a great prevalence of the practice. Through the south generally the prevalence is not marked — Georgia, Arkansas, Texas and Tennessee showing a greater predominance of this practice than North and South Carolina, Kentucky, Mississippi, Louisiana, Florida and Alabama. Oklahoma on the other hand shows in strong contrast to other southern states in the great degree of its prevalence and in the stronger general opinion among the profession in its favor. Ohio, Indiana, Illinois, Iowa, Kansas, Missouri, Nebraska, North and South Dakota and Wisconsin show the greatest prevalence of this practice of anywhere in the United States and the profession is divided between a vigorous opposition to the practice and an equally cynical low standard justifying it. In Minnesota and Michigan the practice, though prevalent, is less widespread than in the other states just mentioned. Secret fee splitting is also fairly prevalent in Utah and Colorado. It is much less so in Arizona, New Mexico, Wyoming and Montana. It becomes prevalent again in Idaho, Washington, Oregon and is exceedingly prevalent in California.

It is interesting to note that in the replies given stating whether or not secret fee splitting was justifiable, there were 77.3 per cent who answered in the negative, 13.4 per cent who answered in the affirmative, and 9.3 per cent who were doubtful.

By the term secret splitting of fees here used is meant the sharing by two or more men in a fee which has been given by the patient supposedly as the reimbursement for the service of one man alone. By secrecy is meant that the division of the fee is done without the knowledge of the patient or some representative of the family. It necessarily does not include any agreement between the patient or his representative made with one or more physicians or surgeons. It also does not include any payment to bona fide assistants with or without the knowledge of the patient or his representative. It does include, however, those cases in which the term assistant is used as a subterfuge to obtain a part of the fee which otherwise could not be rightfully claimed. The term commission here used refers to those rebates, "rake offs," or pro rata moneys sent for referring patients or favors received and not for medical and surgical services rendered to the donor by the receiver.

In the last twenty-five years surgery has developed to such an unprecedented degree compared with its former possibilities that it has entirely changed its relative position to other branches

of medicine. Surgery *per se* compared with internal medicine to-day, as it appeals to the lay mind, is practically the difference between the abstract and the concrete. Surgery is a concrete service of a visible, definite kind easily appreciated by the same average intelligence which fails to appreciate any abstract service however valuable. There is no question that modern surgery has diminished the sum total of human suffering and has added to the average length of human life among the nations in which it is practised to-day. The lay mind sees and appreciates it and is therefore willing to pay for its performance as the only practical return that can be made for the blessings that it gives. But surgery demands a knowledge of detail and a clearness of conception for its best performance, requiring both great manual dexterity and great brilliancy and acuteness of intellect to reach its highest perfection. As a logical sequence to this the pecuniary reward given to different surgeons for, apparently the same service may vary greatly. All this is appreciated by the lay mind; it is unquestioned, its logic is recognized and the rewards that follow in this world's goods are naturally great.

On the other hand medicine has concerned itself and still concerns itself with the more abstract problems of inoperable disease and has cared for the nagging ailments of daily life and the intangible struggle against unseen infections, and it has shown its greatest triumphs in the presentation of disease. It has diminished and prevented an enormous amount of human suffering and it has far outstripped even surgery in its benefit to the race in the prolongation of the years of health and of human life. But great as the service has been, it is a negation compared to the positive action of surgery. The just appreciation of this service and these daily services that a physician gives requires a greater intelligence and a higher civilization than the average human being has reached or possesses. The fees therefore of the physician have lagged behind those of the surgeon and the worldly rewards in internal medicine are not as great as those of surgery. More than that, the rewards given to physicians are on the average given more grudgingly than to the surgeon. The surgical fees are enormously greater than they were twenty-five years ago; medical fees still remain practically the same, and except in a few large centers have hardly advanced at all. Oftentimes, especially in smaller communities, physicians giving their time, draining their personalities, giving of all that is in them, find that the sense of obligation to reward them for their service diminishes in direct ratio as a feeling of friendship from their patient increases, with the result that they cannot collect a fee for an honest, difficult, scientific diagnosis which results in the life-saving operation for their patient, while the surgeon who does the mechanical operation readily collects a relatively large fee.

The value of the services of the general physician are still misunderstood, are still estimated far below their worth. Added

to this the economic pressure on the physician to live on a small income and care for his family is becoming increasingly difficult. It is easy to understand, therefore, that under the strain of the struggle for existence, the physician, seeing his more fortunate brother obtain relatively large fees for apparently easier work, should be filled with envy and his sense of moral obligation and his duty to his patients should suffer in consequence. On the other hand, taking into account the competition among the surgeons for opportunities to work, with a desire to increase their clientele and income, it is easy to understand how they have stifled their consciences and have yielded to the temptation to bid for the work of their wavering confrères. Excuses are easily thought of and easily made. The lower morals and lower standards of the average commercialism which they see around them are easily copied. The younger surgeon desiring to start will make his bids to split his fees and will gain a bigger clientele and become more quickly established. Physicians unable to collect their fees will endeavor to throw the responsibility on the surgeon and obtain through him, as a partial collector from their clients, the moneys which they should collect for themselves directly from their patients. The result is demoralizing to them both. The patient is brought to the surgeon who will split off to the physician the greatest percentage of his fee irrespective of whether or not that surgeon is the best one to perform that operation on that given patient. Furthermore, the temptation soon arises to operate unnecessarily that the surgeon may have his fee and that the physician may obtain his share. From what at first seems but a harmless endeavor to collect part of uncollectable moneys due him for his work, the physician may find himself in the unhappy position of having degenerated into one who dishonestly is exploiting his patient for an unnecessary operation that he may share the proceeds of a dishonorable act. The surgeon who aids and abets in these practices or who trusts to the size of his bid to increase his surgery, has demeaned himself and has equally degenerated from an honorable to a dishonest man.

It is interesting to note the reasons given for this secret fee splitting, as justification, in the statistics which form the basis of this report. One of the commonest reasons is that it is justifiable because of the disproportionate fee between the amount paid the surgeon and the amount paid the physician who has made the diagnosis and referred the patient to the surgeon. This is on the basis that a wrong has been done the physician because his services are not as well paid as the surgeon's. But two wrongs never yet made a right, and the further wrong doing of taking a patient to a surgeon because he will split the most generously does not remedy or make up an injustice however great to the physician. The physician's remedy is along other lines, not one of dishonesty to his patient in which he betrays him according to the size of the

fee obtained. Another reason given is that it is nobody's business what a surgeon does with his fee after he has earned it. But it is the patient's business to know for what he is paying, whether it is that he is paying for the best work obtainable from the best man to perform that work or whether he is paying an inferior man to consummate a dishonest bargain with his physician, and the patient has a legal and a moral right to know which he obtains. Many other reasons are given, all of them expressing in some change of thought and language that the splitting of a fee is justifiable because the patient will pay more readily for the work of a surgeon than for the work of the family practitioner, all of them containing the same fallacy that it is justifiable to exploit a patient for all the money that can be squeezed out of him and not on the basis of giving the best service possible. Other reasons are that fee bills charge too little for medical skill and too much for surgery. Here, too, the remedy lies in the hands of physicians themselves and gives no justification for the exploiting of patients. Other answers are more frankly truthful, such as "purely on the grounds of good business," and "because every one else is doing it," and "unless you do some other man will." These frankly but tacitly admit the low standard of commercialism on which these men have put their profession.

Commissions are of two kinds. First are those which are given pro rata by a consultant for every patient sent to him. This practice is more common in some localities than in others. In one large city it is not uncommon among a certain group of men. Some of them frankly admit that they earn their bare living with their practice, but their main income comes as a steady return from the consultants to whom they send patients, these consultants rendering a definite amount at the first of each month for each patient sent. This, of course, is just plain cynical, dishonest exploitation of the patient. A patient is sent to the man who is willing to be the most dishonest and give the biggest commission and charge the patient for his services according to the ratio of the split he must make and not according to service alone. There is again no consideration whether the patient will receive good or inferior treatment from such consultant.

The other kind of commission is that which is received by physicians from pharmacists or from instrument houses or those commercial houses furnishing medical or surgical supplies and appliances. This form of commission, unfortunately, is exceedingly wide-spread, especially in prescribing or supplying elastic stockings, trusses, belts, braces and similar articles. It is immaterial whether a certain definite commission is sent regularly as each patient is referred, or whether the patient is charged a high retail price for the apparatus and the difference between the retail and the wholesale price to the trade given to the referring surgeon. It is exploiting a patient and obtaining money for service not rendered. The surgeon does not give the appliance to the

patient; the patient buys it from the commercial house and the surgeon has already charged his fee for his advice and his services to the patient. This is grafting on the commercial house for an added fee to be taken from the patient who is supposed to be buying an instrument at a fair price and who is not supposed to be further adding an underhand fee to the surgeon. It is dirty graft, pure and simple, to the disgrace of men who practice it.

There is another form of commission and that is the rebates offered by hospitals or sanatoriums to those sending patients. This has become so wide-spread that many hospitals in their circulars openly offer commissions to those who will send them patients. In some localities those commissions are taken for granted and physicians will call up before sending their patients to these hospitals and sanitariums and ask to be informed of how much rake off they are to obtain — 15 or 20 per cent or even more. In New York 15 per cent is the usual amount demanded among those given to this practice. This is the same dishonest exploitation of a patient. The patient goes to this hospital supposedly paying for service he is to receive, and it is a dishonest betrayal of a patient to take from him in an underhanded way moneys which have not been earned. This cannot be justified; it is straight dishonesty.

All medical practice is contract practice either implied or expressed between the physician and the patient if the patient be of legal age, or between the physician and the parents or guardians of a minor. There is no reason in law or morals why a physician should not enter into a contract with an individual, firm or corporation, provided that the contract be an honorable one for the performance of an honorable act and not interfering with the rights of others. Contract practice here considered is not the contract usually implied but which at times may be definitely stipulated between the physician and the individual patient. The other forms of contracts into which physicians enter are those between the physician or surgeon and business corporations such as railroads, mining, manufacturing and life insurance companies. In another class are those between medical men and benevolent or fraternal associations, the so-called lodge practice. Another kind of contract is that between physicians and the industrial insurance companies. The lodge practice and the industrial insurance work stand out distinctly on a different basis from the other contracts with economic corporations. The contracts made between physicians and economic corporations are necessities in our present stage of economic development. Surgeons and physicians are employed by these corporations partly as a matter of self-protection that they may properly care for the accidents occurring in the transaction of their business and that they may be protected against unjust damage suits that are likely to occur, for should they not be so protected it is possible for these companies to be wiped out of existence in a few years by

the enormous mass of damages brought against them. Besides this self-defence of the company, there is a growing appreciation by large corporations that the better the health of their employees is protected the better will be the results obtained in their work, and hence while it may tend toward benevolent and socialistic ideas, it is really a question of economic efficiency. Further, many lumber and mining camps are widely distant from towns and places where physicians would naturally settle and these camps need some medical man to care for the men employed. All such contracts as these are necessities and should be recognized as such, the only question arising being the details of the contracts and the fairness of the remuneration given. If medical men are poorly paid and paid below the possibility of a fair living wage, they give poor service in return and there is a law of diminishing returns even in the matter of medical services. Poor, underpaid medical service is a foolish and expensive economy to corporations.

In the matter of lodge practice and fraternal and benevolent societies, another situation arises, namely, the question of health insurance. Medical attendance in the lodges and fraternal and benevolent associations is a part of the inducement for the joining of these associations. There is a point in wage earnings at which these lodge medical services are not economic necessities, but on the other hand there is a point in wage earnings at which the ratio of fixed charges to total income is such that these fraternal societies do become an economic necessity in the sense of health insurance. The late Dr. Bristow, in an address before the New York Academy of Medicine, strongly emphasized this point of view. He further showed that in the United States the annual income of adult males is in 90 per cent less than \$800, in 75 per cent less than \$600, and in fully 50 per cent less than \$500, with 20 per cent earning as low as \$200 per annum. It further is a noticeable fact that the smaller the income the larger the family. There is no question that the fixed charges for necessities against a small income are a large proportion of the total of that income. Moreover, with the poor earning their living by a daily wage, if sickness comes on them their income ceases and whatever savings they may have been able to scrape together quickly vanish for the mere necessities of existence. In cities these necessities for medical attention are met by the free dispensaries and free hospitals and the mass of population has become medically pauperized through the sheer necessities of their environment. On the other hand, the result on the medical profession of this economic situation is that hardly more than 10 per cent of the physicians in the United States are able to earn a comfortable income. The medical profession finds that an adequate medical education requires of students a constantly increasing length of time and of money for its attainment. It is the most costly of all the learned professions, and with living expenses constantly increasing and with the physician's opportunities of earning a livelihood from the general population

constantly diminishing, and further with the profession devoted to self-immolation by its constantly increasing development of preventive medicine and sanitation, we are forced to consider the situation as one produced by economic forces and that lodge practice under certain circumstances is one of health insurance that must be accepted and controlled, not condemned and shunned. No one questions the right of any man to take out a health policy in an ordinary health insurance company. No one questions the right of that man by this policy to pay from \$60 to \$300 a year as an insurance against his possibility of accident or disease and possible temporary or permanent invalidism occurring to him in the work peculiar to the medical profession. How then does this differ from the dollar a year that members of the lodges and societies pay for the privilege of obtaining medical services and care in accident and sickness if these misfortunes come to them? There is no difference in principle; there is no difference in the economic necessity of it. As such it should be recognized and treated. The question comes down then to the designation of the weekly or monthly income at which this should be treated as an economic necessity and above which it is an economic luxury. These economic conditions have been reached in the countries of Europe and have recently caused a vigorous struggle between the medical profession and the government in England. It is useless to struggle with "whereas's and resolutions" against these economic facts. It is time for the American Medical Association and its constituent bodies to look these facts squarely in the face, to accept them and by instituting fair control to see that justice is given to the members of their profession and that an equal social justice is given to the poor whose necessity demands this sort of service.

The necessity for action to remedy the evils of secret fee splitting and giving and receiving of commissions is self-evident. Those who are indulging in these practices are bringing the whole profession into disrepute. Many beliefs and standards of society are on trial and the standards of the medical profession are being judged by the public and weighed in the balance. Heretofore the profession has always endeavored to render to all men its best services irrespective of the rewards received. If through secret fee splitting and commissions the standards of the medical profession are changed from giving to patients the best service possible to squeezing from them the biggest attainable fees, then will the medical profession be deemed to have been weighed in the balance and found wanting. The confidence and respect now given it by the public will be destroyed.

The remedies for the conditions here discussed lie partly in the hands of the American Medical Association, partly in the hands of the constituent state and county bodies and partly in the hands of the medical profession as individuals. The secret splitting of fees and the giving or receiving of commissions are

best remedied by the profession announcing that it demands publicity in all transactions between patients and the members of the profession and refuses to sanction the retention on the roster of any of its organizations the names of those who are proved guilty of these practices.

The teaching of the ethics of the medical profession and of the high standards held by this profession should be given to each medical student before graduation. The young men should not be turned loose on the world ignorant of the high ideals and standards which the medical profession always has and always will stand for. Many young men have yielded to the temptation of commercialism because they were ignorant of higher professional standards and knew only the commercial standard of *caveat emptor* — "let the buyer beware." The rules of *caveat emptor* are out of place in the dealings of the medical profession. The physician has himself to blame who, through failure to put a just appraisal on his services and to demand a just reward for them, and who, through failure of endeavor to collect his just deserts, finds himself unappreciated and unrewarded. The foolish ancient idea that accounts must be sent out but once or twice a year, lax systems of accounts and collections, have much to do with the small incomes and many physicians. The human mind appreciates most those things obtained through struggle and for which a price has been given. It appreciates least those things which have come unsought and unpaid for. In a physician's service human sympathy, kindness and sturdy friendship are thrown in for good measure to time spent and knowledge given, and though desirable, are imponderable and are to be left unmeasured. But time and knowledge can be measured and used for basis of recompense, and although it may seem an abstract service, it is one the public can appreciate and can be educated to realize that it has a value as high as things tangible and concrete. Surgeon's fees are based on a broader consideration of the value and amount of service rendered than are those of physicians. But the latter are expected to charge the same for a call to relieve a sniveling coryza as one to relieve the pains and dangers of angina pectoris. For this reason the fees of surgeons are likely to remain near their present level but the fees of physicians must gradually change and grow to be more in proportion to services rendered than at present. Lack of frankness between the profession and their patients and lack of friendly assistance between surgeon and physician in discussing with patients the business side of the services given, are fertile sources of misunderstandings and opportunities of sly practices, while the reverse is equally true that frankness and definite understandings between medical men and patients prevent these evil practices.

The replies received by the Judicial Council on the matter of contracts in mines and railroads and factories show that in some states the contracts are just and that the recompense

to the physician is in ratio to services rendered and is adequate in amount for such services. On the other hand there are other replies which show the reverse. The Judicial Council believes the remedy for these evils resides in the county societies, that these societies should use their influence and power not to condemn the physician who must take the contract by ostracizing him, but to prevent underbidding for these contracts below what would give a fair reward for medical services rendered. So, too, in the matter of lodge practice, the Judicial Council believes it to be the duty of the local county societies to endeavor to reform and not alone to condemn the abuses of lodge practice. These abuses are many and are unfair alike to the medical man and to the lodge members. But because lodge practice is the expression of health insurance it must sooner or later be faced. The British Medical Association has faced these problems and the American Medical Association will do well to consider seriously similar action. Properly controlled, the lodge practice should bring an adequate service to its members and an equitable remuneration to the medical man. The details, however, are to be left to each locality and county society. From the experience of the British Medical Association it is evident that there should be an income limit (put at ten dollars a week in England), free choice of doctor by patient among the doctors under contract, and consent of doctor to act, the medical profession to be in control and to administer the medical and maternity benefits and the medical remuneration to be what the profession considers adequate (\$2.12 in England) and the method of remuneration of the medical practitioner adopted by each local health committee to be according to the preference of the majority of the medical profession in that locality.

The Judicial Council recommends for adoption by the House of Delegates the following resolutions:

Resolved, That any member of the American Medical Association found guilty of secret fee splitting or of giving or receiving commissions shall cease to be a member of the American Medical Association.

Resolved, That the House of Delegates of the American Medical Association recommends to each constituent body that it endeavor through the action of its various county societies to reform the various abuses of lodge practice in their separate communities in order that the lodges may give an adequate service to its members and an honorable remuneration to the medical men. (49)

Respectfully submitted,

ALEXANDER LAMBERT, Chairman.

A. B. COOKE.

JAMES E. MOORE.

HUBERT WORK.

GEORGE W. GUTHRIE.

ALEXANDER R. CRAIG, Secretary.

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Bulletin of the Massachusetts Medical Society

No. 1. July 1, 1914

PROCEEDINGS

OF THE

COUNCIL

OCTOBER AND DECEMBER, 1913, AND
FEBRUARY, 1914



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October 1, 1913

December 30, 1913

February 4, 1914

THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT

PHYSICS 101

LECTURE 1

MECHANICS

LECTURE 2

MECHANICS

LECTURE 3

MECHANICS

LECTURE 4

MECHANICS

LECTURE 5

MECHANICS

Massachusetts Medical Society.

PROCEEDINGS OF THE COUNCIL.

OCTOBER 1, 1913.

A STATED MEETING of the Council of the Massachusetts Medical Society was held in the Boston Medical Library, October 1, 1913, at twelve o'clock noon, the President, Dr. W. P. Bowers, in the chair, and the following eighty-eight councilors present:

<i>Barnstable.</i>	<i>Hampden.</i>	L. M. Palmer
C. W. Milliken	J. M. Birnie	C. E. Prior
		Godfrey Ryder
<i>Berkshire.</i>	<i>Hampshire.</i>	E. H. Stevens
L. A. Jones	A. G. Blodgett	Julia Tolman
		G. T. Tuttle
<i>Bristol North.</i>	<i>Middlesex East.</i>	H. P. Walcott
R. D. Dean	H. B. Jackson	Alfred Worcester
F. A. Hubbard	G. N. P. Mead	
S. D. Presbrey		
<i>Bristol South.</i>	<i>Middlesex North.</i>	<i>Norfolk.</i>
W. A. Dolan	J. A. Gage	A. N. Broughton
J. H. Gifford		G. G. Bulfinch
H. G. Wilbur	<i>Middlesex North.</i>	Samuel Crowell
	W. P. Lawler	P. J. Fleming
	C. E. Simpson	F. W. Goss
<i>Essex North.</i>	<i>Middlesex South.</i>	T. E. Guild
F. W. Anthony	M. H. Bailey	A. H. Hodgdon
R. V. Baketel	H. T. Baldwin	S. A. Houghton
J. E. Bryant	F. J. Barnes	G. W. Kaan
E. H. Noyes	F. E. Bateman	Bradford Kent
F. W. Snow	J. E. Cleaves	J. S. H. Leard
	C. H. Cook	C. W. Macdonald
<i>Essex South.</i>	E. A. Darling	Charles Malone
J. A. Bedard	G. W. Gay	F. W. Sleeper
J. F. Donaldson	W. H. Keleher	
A. H. Martin	J. B. Lyons	<i>Norfolk South.</i>
	S. F. McKeen	C. S. Adams
<i>Franklin.</i>	C. E. Mongan	O. H. Howe
G. P. Twitchell		E. N. Mayberry

<i>Plymouth.</i>	F. J. Cotton	<i>Worcester.</i>
Gilman Osgood	W. H. Devine	W. P. Bowers
F. G. Wheatley	W. H. Grainger	W. J. Delahanty
	F. B. Harrington	O. H. Everett
<i>Suffolk.</i>	J. B. Hawes, 2d	Homer Gage
H. D. Arnold	W. L. Richardson	R. W. Greene
S. H. Ayer	J. D. K. Sabine	L. F. Woodward
F. G. Balch	F. C. Shattuck	
J. B. Blake	G. B. Shattuck	<i>Worcester North</i>
E. M. Buckingham	A. K. Stone	A. E. Mossman
W. L. Burrage	C. F. Withington	W. F. Sawyer

The minutes of the last meeting were read and accepted.

The President announced the recent death of Dr. Edwin B. Harvey, for thirty years a councilor and also an ex-president of the society, and that of Dr. Reginald H. Fitz, for many years a councilor. He then made the following remarks:

"Although the first meeting of our business year occurs in June, so much time is consumed in affairs connected with the annual meeting of the society, the hearing of reports, and the election of officers, that it seems inopportune to suggest topics for discussion, or plans for work, at that time. This second meeting of the year is a more fitting time for suggestions as to changing or enlarging the scope of our activities.

"Last year your President recommended a few plans, some of which have been considered and acted upon. Your attention is again called to the desirability of a consideration of the Malpractice Act, for if this act is to be continued in force there are certain features which should be carefully studied, such as the question of excluding from the benefits of defence fellows who have insurance with regular companies.

Second: A more exact definition of the kind of suits which are to be defended, i.e., should a fellow evidently negligent be defended, or suits involving blackmail pure and simple.

Third: Should any suits be settled either by the fellows or by the Society.

Fourth: Should medical experts receive any compensation when called as witnesses.

Fifth: Should this subject be under the control of a special committee, as is the case in some state societies. At present it is left to the President and Secretary.

Sixth: Should the fellows of the society be persistently notified of the existence of this protection. At present, the knowledge which we have of this act is not general.

Seventh: Should all fellows, irrespective of their means, be urged to avail themselves of this act.

"These and other questions may properly be considered by a committee and a report made at a subsequent meeting.

"The question has been raised as to the responsibility of our society relating to the appointment of medical men to public office. There is in process of formation an unofficial voluntary committee which will endeavor to work for good appointments; but you should consider whether it would not be wise to have an addition to the list of regular committees which will have official responsibility along this line.

"A very important suggestion relating to the development of regular publications of the activities of the society has been made. This is a subject of great interest and might be of value. You should study the problem and come to some definite conclusion in the near future.

"Your president has become more familiar with the work done by your Secretary and Treasurer, and is of the opinion that these officers are not receiving the compensation to which they are entitled. These matters have not been considered by the council for several years, and should be reviewed and acted upon.

"Your responsibility for the standing and fitness of your members is great, and regular concerted efforts should be made to keep the average doctor up to the requirements of modern practice. And not only physicians, but the public, should be systematically instructed in those matters which they are able to assimilate and use in the promotion of health and the prevention of disease. A campaign of this sort should not be desultory or spasmodic, but rather a concerted movement, arranged for and planned out by men in this society who know best what is needed and how that want can be supplied. At the earliest possible time you, as the executive body of the society, should take this matter in charge.

"Because of the necessity of a larger income, the question of the expense of the annual dinner is important. Many states require the participants to pay a part, or even the whole cost, of this entertainment; and with us, even a partial payment of this outlay would relieve the society of a serious burden and enable us to develop actively along the lines suggested above."

The Committee on Membership and Finance reported through Dr. Goss as follows:

The Committee on Membership and Finance reports and respectfully recommends that these fellows be allowed to change their district membership without a change of legal residence.

- . D. Harold Walker from Norfolk to Suffolk
- George W. Morse from Worcester to Suffolk

Also, that the resignations of the following be accepted:

- George R. Callender, U. S. Army
- Helen B. Carpenter, Seattle, Wash.
- Alden V. Cooper, Hinesburg, Vt.
- Robert K. B. Knowles, Entwistle, Alberta, Can.

Eliza B. L. Norton, Norwood
Charles S. Wright, Portland, Me.

Also, that the following be placed on the retired list:

Albert D. Kingsbury, Needham
Alfred W. La Vigne, Lowell
William H. Wescott, Roxbury

Also, that the following be deprived of the privileges of fellowship for non-payment of dues:

Joseph L. Ameno, New York, N. Y.
Freeman D. Bosworth, Jr., Richmond, Va.
Thomas J. Brennan, Little Compton, R. I.
Orestes M. Brown, Everett
Adelbert A. Bryson, Roxbury
Homer A. Bushnell, North Adams
Nelson C. Davis, Dorchester
George W. Derrick, Norwood
Marland H. Eaton, Beverly
George C. Gates, Chicopee
Howard A. Gibbs, Attleborough
William P. Grovestein, North Scituate
William A. Hare, Springfield
Frank P. Hudnut, Brookline
James H. Joyce, Salem
George F. Keenan, Boston
Joseph E. Lanoie, Montreal, Can.
Harold K. Marshall, Manila, P. I.
James H. McCann, South Framingham
John S. McCormack, Jamaica Plain
Carl E. Meyer, Chicopee
George C. Moore, Boston
Vernon H. C. Morse, Avon, Conn.
Edward E. Myers, New York, N. Y.
Alden R. Newhall, Holliston
James A. O'Reilly, St. Louis, Mo.
Frederic J. Peirce, Atlantic
William H. Raymenton, Worcester
George E. Reynolds, Pittsfield
Carl W. Rosenbloom, Holyoke
Henry C. B. Snow, Buzzards Bay
William L. Thompson, Boston
Willis L. Tucker, Hinsdale
Horace G. Webber, Wilbraham
Frank B. Worthing, Chatham
Frederic J. Wurtele, Denver, Colo.

Voted, To accept the report and adopt its recommendations.

The reports of the committees appointed to consider the petitions of J. D. Clark, O. R. Fountain, J. W. McKoan, J. H. Costello and M. Gerstein, to be restored to the privileges of fellowship, were acted upon favorably; and the report of the committee appointed to consider the petition of W. H. Davis (namely, that it could not consider the petition in the form in which it was written) was accepted.

The resignation of Dr. H. D. Arnold as a member of the committee on medical education and medical diplomas was accepted with regret. On nomination by the president, Dr. Channing Frothingham, Jr., was appointed a member of this committee in place of Dr. Arnold.

On nomination by the president, Drs. Vanderpoel Adriance, of Williamstown, and W. O. Wilder, of Pittsfield, were appointed delegates to the annual meeting of the Vermont State Medical Society.

Dr. Homer Gage reported progress for the committee on the revision of the boundary line between the Suffolk and the Norfolk Districts, and asked that the committee be continued; and it was so voted.

Dr. H. D. Arnold reported for the delegates of the Massachusetts Medical Society to the House of Delegates of the American Medical Association. The following topics were considered:

Credentials of delegates; Membership and fellowship; Uniform regulation of membership; Relation of the A.M.A. to constituent State associations in matters of health and public instruction; National department of health; Medical education; The secret splitting of fees and "contract" practice; Sections; New section on Gastro-enterology and Proctology; Elections; Next meeting place; Delegates to the A.M.A. Dr. Arnold concluded his report as follows:

"For six consecutive years I have had the honor of acting as a delegate of the Massachusetts Medical Society to the A.M.A., and I have attended all the meetings of the House of Delegates during that period. In relinquishing this position, I wish to express my appreciation of the honor thus conferred, not only by re-election for this period, but by the favorable action of this society on all the essential recommendations which have been made from time to time in connection with this service. I trust you will pardon me if I add a few comments and suggestions based on this experience.

"At the beginning of this service, Massachusetts counted for little in the councils of the A.M.A. and in the important move-

ments which the association was undertaking. These movements were for the benefit of the public and the profession, and Massachusetts should have been one of the leaders. This state of affairs was due in part to apathy on the part of our society as to its relations to the A.M.A., but chiefly to a lack of appreciation of the importance of the position of delegate, of the importance of having a full representation in the House of Delegates, and of having delegates serve terms long enough for them to become familiar with the machinery of the business organization. In a previous communication to the council, I pointed out that usually there had been an attendance of only two or three delegates, although the society was entitled to six, and that a man rarely attended even two years in succession. A man needs time to learn how the business is conducted, to become acquainted with the men who are working for the benefit of the profession, and to become known by them. Until this is accomplished, he can do little in the way of accomplishment, and his state society can have little influence.

"All this is now changed. I wish little credit for it personally — only for a willingness to devote a certain amount of time and energy to these matters when I would have preferred to attend scientific or social occasions. We have had loyal co-operation by all the Massachusetts delegates. They have stood together for the ideals that the Massachusetts Medical Society stands for, and they have been heard from in some of the controversies. The association now knows that Massachusetts is an important factor and that it is always to be found on the side of what is right.

"From my report of the action of the House of Delegates, it must be clear to all that that body has to deal with many questions in which the society is vitally interested. Our society wishes to do its share in these important movements. It must also be ready to protect its own interests. For both these reasons there should always be a full delegation. In addition, delegates should be chosen who are able and willing to take part in the work of deliberation and administration, and at least two of the men should be serving terms of at least four years. It is important always to have present at least one man who has served at least two years and who is familiar with the situation. The medical profession is not free from self-seekers. The large influence of the association and its accumulating funds are an attraction to those who seek power for their own selfish aims. Politicians, in the real sense of the word, are developed. The experience of the past few years has shown that a few such men could, by skilful combination of effort, gain control of the association if the better elements — a very large majority — do not maintain a watchful organization. These same years have shown also that these better elements, if organized, can pull the association out of perilous situations. The danger will return, however, and Massachusetts should adopt a permanent policy that will aid in making the association what

it should be — a representative body of the whole medical profession of the country."

Voted, To accept the report and place it on file.

Dr. Gay moved and it was voted that the cordial thanks of the Society be extended to Dr. Arnold for his efficient service as a delegate to the A.M.A.

On motion by Dr. Arnold, the following votes were passed:

Voted, That the Secretary be instructed to send to each member of the Society a copy of that part of the report of the Judicial Council of the American Medical Association which refers to secret fee splitting and "contract" practice.

Voted, That a committee be appointed to consider the relations of the Massachusetts Medical Society to the American Medical Association and to other state societies, and that it make a report to the council at its annual meeting.

This committee shall consist of the following officers: The President, Vice-president, Secretary, Treasurer, and the following to be chosen by the President: One member of the committee on membership and finance, two presidents of district societies, two secretaries of district societies, two of the delegates to the American Medical Association who attended the last meeting of the House of Delegates.

Dr. George W. Gay introduced the following preambles and resolutions, which were passed unanimously:

Whereas: Dr. Edwin Bayard Harvey, one of the oldest members of the Massachusetts Medical Society, has recently passed away, and

Whereas: He was for nearly half a century an active and loyal member of the society, always interested in its welfare, at one time its president and for more than thirty years a councilor, and

Whereas: He was the originator of and sponsor for the bill establishing the present Board of Registration in Medicine in this state and for seventeen years its efficient secretary; also the father of the bill which supplies free text-books to the pupils of the public schools of the state, and

Whereas: He has rendered valuable service to the public and to the profession upon many occasions in shaping and guiding wise legislation, as well as in opposing pernicious legislation; now, therefore, be it

Resolved: By the council of the Massachusetts Medical Society in session assembled, that it is deeply sensible of Dr. Harvey's many excellent qualities, as well as of the valuable services rendered the public and the profession during a long and active life.

Resolved: That in the opinion of this council, Dr. Harvey's death is a distinct loss to the Commonwealth, which he has served

so faithfully, and to the profession, to which he has been loyal, and which has now been deprived of his sound judgment and wise counsel.

Resolved: That the secretary be directed to send a copy of these resolutions to Mrs. Harvey and also to the *Boston Medical and Surgical Journal* for publication.

Dr. Withington raised the question of the compensations of the secretary and treasurer of the society, stating that in his opinion they were inadequate for the time and effort expended. He moved, and it was

Voted, That the committee on membership and finance be requested to consider the subject of the salaries of the secretary and treasurer and report at a subsequent meeting of the council.

Dr. Cotton spoke for the committee of the Society on the Workmen's Compensation Act, and introduced the following motion:

Moved, That the president be empowered to direct the legal counsel of the Society to bring before the Superior Court, and if need be the Supreme Court, a test case under Part III, Sections 11 and 16, of the Workmen's Compensation Act (Chapter 751, Acts of 1911, as amended by Chapters 172 and 571, Acts of 1912) in order to clear up in part the vexed matter of the ultimate payment of physicians' fees in disputed cases.

The motion was discussed by Drs. Cotton, Cook and Dolan, and was passed.

Dr. Ryder discussed the question of the present working of the Society's Act for the Defence of Malpractice Suits. He read the following statement of the cases of malpractice which has been placed in the hands of the attorney for the Massachusetts Medical Society from June 10, 1908, when the Act went into effect, to October 1, 1913, fourteen cases in all.

Disposal of these cases:

Settled	4 cases
Verdict for defendant	2 cases
Suit withdrawn	3 cases
No suit brought	2 cases
Insurance Co. forced by our attorney to defend suit	1 case
Pending	2 cases
Total	14 cases
Total cost of malpractice defense to date	\$1926.00
Average cost per year	\$385.00

In addition to these fourteen cases, the secretary has discussed malpractice defence cases and furnished application blanks and

copies of the act to approximately sixty (60) fellows during the time the act has been operative.

Dr. Ryder read seven suggestions which had been advanced for the perfecting of the Malpractice Act and to make it of greater use to the largest number of fellows.

He moved, and it was

Voted, That a committee be appointed by the president to consider the working of the Malpractice Act and to report at a subsequent meeting of the council what changes in the act, if any, are advisable. The president appointed the following committee: Godfrey Ryder, G. W. Gay, F. W. Goss, Hugh Cabot, A. N. Broughton.

Dr. Homer Gage spoke of the matter of publications. He said that the society often failed to get information about matters of general interest to the members promptly and the question had arisen as to how to meet this difficulty satisfactorily. Three suggestions had been made:

1. That a special department devoted to the affairs of the society should be created in the *Boston Medical and Surgical Journal*, and that every member of the society should receive a copy of the *Journal*.

2. That the society should take over the *Boston Medical and Surgical Journal*. And

3. That the present quarterly publication published by the society should be developed along larger lines so that more frequent numbers should be issued.

Dr. Gage moved, and it was

Voted, That the question be referred to the committee on publications and scientific papers, with a request that a report from this committee be given at the next meeting of the council.

On motion by Dr. L. M. Palmer, it was

Voted, That the president appoint a committee of five to draw up resolutions on the death of Reginald Heber Fitz.

Adjourned at 1.20 P.M.

WALTER L. BURRAGE,
Secretary.

SPECIAL MEETING. DECEMBER 30, 1913.

A SPECIAL MEETING of the Council of the Massachusetts Medical Society was held December 30, 1913, at twelve o'clock noon, in Sprague Hall, Boston Medical Library, with the president, Dr. W. P. Bowers, in the chair. The following sixty-two members of the council were present:

<i>Berkshire.</i>	J. E. Cleaves	F. G. Wheatley
L. A. Jones	C. H. Cook	
	E. A. Darling	<i>Suffolk.</i>
<i>Bristol North.</i>	G. W. Gay	H. D. Arnold
A. R. Crandell	A. A. Jackson	J. B. Blake
R. D. Dean (V-P)	C. E. Mongan	E. M. Buckingham
F. A. Hubbard	E. H. Stevens	W. L. Burrage
	Julia Tolman	Hugh Cabot
	H. P. Walcott	G. A. Craigin
<i>Bristol South.</i>		J. W. Farlow
G. deN. Hough	<i>Norfolk.</i>	J. B. Hawes
H. G. Wilbur	A. N. Broughton	J. J. Minot
	G. G. Bulfinch	M. W. Richardson
<i>Essex North.</i>	A. H. Davison	J. D. Kelly Sabine
R. V. Baketel	H. C. Ernst (C)	G. G. Sears
	E. W. Finn	F. C. Shattuck
<i>Essex South.</i>	F. W. Goss	G. B. Shattuck
J. A. Bedard	A. H. Hodgdon	A. K. Stone
H. L. Paine	John Homans (C)	C. F. Withington
	G. W. Kaan	Grace Wolcott
<i>Middlesex East.</i>	C. W. Macdonald	
D. C. Dennett	Charles Malone	<i>Worcester.</i>
	A. R. Sawyer	W. P. Bowers
<i>Middlesex North.</i>	A. E. Sherburne	C. A. Church
J. A. Gage (C)		O. H. Everett
C. E. Simpson (V-P)	<i>Norfolk South.</i>	David Harrower
	E. N. Mayberry	W. G. Reed
<i>Middlesex South.</i>		S. B. Woodward
H. T. Baldwin	<i>Plymouth.</i>	
F. E. Bateman	A. E. Paine	

(V-P) or (C) following a name indicates he is a member of the council through holding office as Vice-President *ex officio*, or as chairman of a standing committee.

The minutes of the last meeting were read and accepted.

Dr. Hugh Cabot spoke on the midwife question. He thought the society through its council should give definite instructions to its committee on state and national legislation because in the

committee hearings at the State House, this committee has been made to appear to be without authority and the policies which it favors are regarded as personal expressions of opinion rather than those advocated by the Massachusetts Medical Society. Dr. Cabot presented the following letter to the president, dated Oct. 6, 1913, which was signed by the Obstetrical Society of Boston and by forty-four physicians of Boston, Haverhill, and Springfield:

"Last year in the Legislature, by House Bill No. 678, an attempt was made to legalize the midwife and admit her on equal terms with the physician to the practice of Obstetrics. Certain members of the Massachusetts Medical Society favored this bill. In all probability there will be another attempt this year to legislate in the midwives' favor. By a decision of the Supreme Court handed down by Justice Rugg, *Commonwealth v. Porn*, the midwife was excluded from practicing obstetrics. Yet in Chapter 29 of the revised laws of the Commonwealth the word *midwife* repeatedly occurs (Section III, "a midwife shall make and keep a record, etc.," "the fee of the physician or midwife shall be twenty-five cents"; later, "the physician or midwife who neglects"), thus seeming to give her a legal status. There are persistent reports about Boston that members of the Massachusetts Medical Society are signing birth returns of infants delivered by midwives, the physician not being in attendance. We, the undersigned, members of the Massachusetts Medical Society, feel that the practice of obstetrics is a vital and essential branch of the practice of medicine and that no training other than that leading to the degree of M.D. is to be considered adequate or sufficient for engaging in this practice. We recognize that this consideration may, however, demand an ideal situation. Therefore, until public sentiment can be roused sufficiently to raise the standard of obstetrics so that the midwife is admitted to be an unnecessary evil, we advise that no legislation should be sanctioned by the Massachusetts Medical Society other than bringing the statute books up to date by omitting the word *midwife* wherever it occurs in those sections pertaining to the reporting of births.

As a step in advancing the status of the practice of obstetrics, we ask you to bring before the council of the society the proposal that the practice, said to be carried on by certain doctors, of returning certificates on cases over which they have had no supervision, and failing to state that they were not in attendance, is contrary to the ethics of this society; that any member so doing is guilty of a misstatement of fact and should be debarred from the privileges of this society.

In order to bring the matter into definite form, Dr. Cabot presented the following preambles and resolutions:

Whereas, by Chapter 76, Sections 8 and 9, of the Revised Laws of the Commonwealth of Massachusetts, the midwife was ex-

cluded from the practice of her profession within the confines of this state, and by a decision of the Supreme Court handed down by Justice Rugg in the case of the Commonwealth *v. Porn* the law was held to directly cover the activities of the midwife and thus made effective;

And whereas, Chapter 29 of the Revised Laws of the Commonwealth of Massachusetts repeatedly uses the word midwife (Section 3, "Physician and midwife shall make and keep a record," etc., and later, "the fee of the physician or midwife shall be twenty-five cents," etc., and later, "The physician or midwife who neglects," etc.), thus seeming to give her legal status;

And whereas, by House Bill 678 presented to the Great and General Court of the Commonwealth of Massachusetts, January 9, 1913, a definite, although unsuccessful, attempt was made to legalize the midwife and admit her on equal terms with the physician to the practice of obstetrics, this bill being favored by certain members of the Massachusetts Medical Society;

And whereas, persistent reports are being received that members of the Massachusetts Medical Society are signing birth returns of infants delivered by midwives without a physician in attendance;

Be it resolved, that we, the council of the Massachusetts Medical Society, put ourselves on record as of the firm opinion that the practice of obstetrics is a vital and essential branch of the practice of medicine and requires the care and supervision of a graduate in medicine, and that there is no place for the untrained practitioner in this field of medicine within the Commonwealth of Massachusetts; that no training other than that leading to the degree of M.D. is to be considered adequate or sufficient for engaging in this practice; that untrained persons practicing obstetrics are in open defiance of the law and should be prosecuted when apprehended; that as soon as public sentiment within and without this society can be sufficiently aroused, a bill shall be presented to the Great and General Court of the Commonwealth of Massachusetts which shall provide for the omission of the word midwife from the statute books, thus bringing the law up to date; that members of this society are hereby enjoined from handing in birth returns on cases over which they have had no supervision when delivered by a midwife; and that it is the opinion of this body that a physician signing a birth return assumes the responsibility for that case.

These were discussed by Drs. H. P. Walcott, F. C. Shattuck, H. D. Arnold, F. E. Bateman, C. H. Cook, the president, and Dr. C. F. Withington. Dr. Withington pointed out four alternatives that are open at this time: 1. To leave the present law; 2. To leave the present law with the elimination of expressions which tolerate or legalize midwives; 3. To legislate positively

prohibiting midwives to practice; and 4. A licensure of midwives after examination.

The question was further discussed by Dr. Buckingham and others. The preambles and resolutions being put to a vote, were adopted unanimously.

It was moved and

Voted, That the committee on ethics and discipline be directed to look into the matter of the signing of birth certificates by fellows who have not been actually in attendance, and to take such action as it deems advisable.

Dr. M. W. Richardson, for the committee on public health, presented the question of ophthalmia neonatorum, and made the following motion:

Moved, That the council approves amending Section 49 of Chapter 75, of the Revised Laws relative to the better control of ophthalmia neonatorum as follows:

"Section 49 of Chapter 75 of the Revised Laws is hereby amended by adding after the word "necessary" in the eighteenth line, the following words: "including as far as may be possible consultation with an oculist and the employment of a trained nurse."

This was discussed (by invitation) by Dr. F. E. Cheney. He said that in recent years he had treated many cases of ophthalmia neonatorum at the Massachusetts Charitable Eye and Ear Infirmary; that last year, in 20 per cent of the cases that were admitted blind, the blindness was due to ophthalmia neonatorum. He read extracts from data as to seven members of the Massachusetts Medical Society who had been derelict either in reporting or in treating cases of ophthalmia neonatorum, most of these being in the neighborhood of Boston, and none in the remote country districts. The inexperienced practitioner rarely notices the involvement of the cornea in these cases, and thinks that because the discharge has become less, the cornea is not affected. Dr. Cheney thought that the Massachusetts Medical Society should go on record as opposed to the treatment of cases of ophthalmia neonatorum by the general practitioner, and he favored Dr. Richardson's motion. After some further discussion, the motion was put by the president and passed unanimously.

Dr. M. W. Richardson, for the committee on public health, read the five sections of an act to enable the State Board of Health to better protect the public health through adequate supervision of the conditions under which milk is produced, transported, kept for sale, and sold, and he moved that it be approved by the council; and on being put to a vote, it was approved unanimously.

The president nominated the following as a committee to audit the treasurer's accounts, and they were elected:

D. N. Blakely, Brookline
J. L. Huntington, Boston

Dr. Homans, for the committee of arrangements asked for advice from the council as to the annual dinner. He pointed out that the expense had increased of late, and queried whether it was worth while to spend so much on the dinner when the other activities of the society needed part of the funds. His committee planned to charge a nominal amount, say, one dollar, apiece, to cut down the expense of the dinner, but not to change the character of the dinner; and he made a motion that the committee of arrangements be instructed if it sees fit to impose a charge of one dollar on all fellows who attend the annual dinner.

Dr. Broughton pointed out that the last dinner was not more expensive per diner than usual, but that more fellows attended; and that each one over one thousand (the number contracted for) cost fifty cents extra. Dr. Hough said that he didn't see why the two-thirds of the society who did not attend should pay for the third who ate the dinner, and that he thought there were very many fellows who did not require an elaborate dinner and would rather have the funds of the society expended for more worthy ends.

Motions were made to substitute two dollars and three dollars in place of the one dollar in the original motion. On being put to a vote, these were lost.

On motion by Dr. Arnold, the words "if it sees fit" were struck out of the motion, and the amendment being accepted by Dr. Homans, the motion was passed as amended.

Dr. Goss, for the committee on membership and finance, reported as follows:

The committee on membership and finance reports that at a meeting of the council held October 1, 1913, the following votes were passed:

I. That its secretary be instructed to send to each member of the society a copy of that part of the report of the Judicial Council of the American Medical Association which refers to secret fee splitting and "contract practice."

II. That the president be empowered to direct the legal counsel of the society to bring before the Superior Court, and if need be before the Supreme Court, a test case under Part III, Sections 11 and 16, of the Workman's Compensation Act (Chap. 751, Acts of 1911, as amended by Chaps. 172 and 571, Acts of 1912) in order to clear up in part the vexed matter of the ultimate payment of physicians' fees in disputed cases.

By direction of the president, these votes were referred to the committee on membership and finance. A meeting of the committee was held on October 13, 1913, and after full discussion, it was voted to recommend to the council that \$64.00 be appropriated from the treasury of the Massachusetts Medical Society for the printing and distribution to its members of that part of the report of the Judicial Council of the American Medical Association relating to secret fee splitting and contract practice.

Also, that \$100.00 be appropriated to enable the legal counsel of the society to bring before the courts a test case to clear up in the Workman's Compensation Act the matter of the ultimate payment of physicians' fees in disputed cases.

Voted, To accept the report and adopt its recommendations.

A new petition of Dr. W. H. Davis of Dorchester to be reinstated as a fellow was read by the secretary, and also the report of the committee appointed to consider the petition, which recommended his reinstatement provided he pay what he owes the society within one month from December 30, 1913.

Voted, To accept the report and adopt its recommendations.

The following committees were appointed to consider petitions for reinstatement:

F. P. Hudnut, New Bedford	{ G. deN. Hough C. A. Bonney E. E. Robbins
C. W. Rosenbloom, Holyoke	{ G. L. Taylor J. L. Bliss F. H. Allen
A. E. Bertrand, Lowell	{ E. G. Livingston G. E. Caisse E. J. Clark
Dixie G. Hoyt, Providence, R. I.	{ W. L. Munro A. E. Hayes J. G. O'Meara
G. C. Moore, Boston	{ R. W. Lovett F. L. Richardson A. T. Legg
G. F. Keenan, Boston	{ F. B. Lund H. A. Lothrop M. J. Cronin

The treasurer spoke of the case of the estate devised under the will of Isaac P. Smith, late of Gloucester, a fellow of the Massachusetts Medical Society, who died in 1862, and said that the Massachusetts Medical Society is a residuary legatee but that there are so many young heirs at law the possibility of the society's

receiving anything from the will is rather remote. He queried whether the president had authority to sign documents relating to the estate submitted by the trustee, and whether the society should bear any of the legal expenses connected therewith.

On motion by Dr. H. P. Walcott, it was

Voted, That the president be authorized to do as he sees fit in the case of the Isaac P. Smith will, without expense to the society.

Voted, That the two bills submitted by the committee on public health be introduced to the legislature by some member of the council, and that the committee on state and national legislation be instructed to support the measures.

The president announced the death on December 20th of Dr. A. E. Mossman, of Westminster, councilor and supervisor.

Adjourned at 1.45 P.M.

WALTER L. BURRAGE,
Secretary.

FEBRUARY 4, 1914.

A STATED MEETING of the Council of the Massachusetts Medical Society was held at the Boston Medical Library, February 4, 1914, at twelve o'clock noon, the president being in the chair and the following eighty-eight councilors present:

<i>Barnstable.</i>	<i>Franklin.</i>	<i>Middlesex South.</i>
C. W. Milliken	G. P. Twitchell	H. T. Baldwin
<i>Bristol North.</i>	<i>Hampden.</i>	F. E. Bateman
A. R. Crandell	T. S. Bacon	J. E. Cleaves
R. D. Dean (V-P)	J. M. Birnie	C. H. Cook
<i>Bristol South.</i>		G. W. Gay
W. A. Dolan	<i>Hampshire.</i>	A. A. Jackson
J. H. Gifford	M. W. Pearson	C. E. Mongan
G. deN. Hough	W. P. Stutson (V-P)	L. M. Palmer
H. G. Wilbur		C. E. Prior
<i>Essex North.</i>	<i>Middlesex East.</i>	Godfrey Ryder
R. V. Baketel	D. C. Dennett	E. H. Stevens
E. H. Noyes	H. B. Jackson	Julia Tolman
F. B. Pierce	G. N. P. Mead	Alfred Worcester
F. W. Snow		<i>Norfolk.</i>
<i>Essex South.</i>	<i>Middlesex North.</i>	E. F. Bartol
J. A. Bedard	J. A. Gage (C)	G. G. Bulfinch
A. H. Martin	W. P. Lawler	Samuel Crowell
H. L. Paine	R. J. Meigs	A. H. Davison
H. E. Sears	C. E. Simpson (V-P)	F. P. Denny
J. J. Shea		E. W. Finn
		P. J. Fleming

F. W. Goss	<i>Suffolk.</i>	A. K. Stone
T. E. Guild	H. D. Arnold	C. F. Withington
A. H. Hodgdon	J. W. Bartol	
S. A. Houghton	J. B. Blake	<i>Worcester.</i>
G. W. Kaan	E. G. Brackett	W. P. Bowers
Bradford Kent	E. M. Buckingham	C. A. Church
T. J. Murphy	W. L. Burrage	W. J. Delahanty
A. R. Sawyer	Hugh Cabot	O. H. Everett
B. E. Sibley	F. J. Cotton	Homer Gage
F. W. Sleeper	G. A. Craigin	R. W. Greene
C. F. Stack	W. H. Devine	L. F. Woodward
	J. W. Farlow	S. B. Woodward
<i>Norfolk South.</i>	F. B. Harrington	
C. S. Adams (V-P)	J. D. K. Sabine	<i>Worcester North.</i>
O. H. Howe	G. G. Sears	W. F. Sawyer (V-P)
E. N. Mayberry	G. B. Shattuck	

(V-P) or (C) following a name indicates he is a member of the council through holding office as Vice-President *ex officio*, or as chairman of a standing committee.

The minutes of the last meeting were read and accepted.

The following delegates were nominated by the chair and duly appointed.

Delegates to the American Medical Association for two years.

J. B. Blake, Boston. Alternate, Gilman Osgood, Rockland.

H. G. Stetson, Greenfield. Alternate, L. A. Jones, No. Adams.

L. F. Woodward, Worcester. Alternate, J. F. Burnham, Lawrence.

For one year: Alternate, R. I. Lee, Boston.

Delegates to Maine Medical Association,

F. W. Snow, Newburyport; F. W. Anthony, Haverhill

Delegates to New Hampshire Medical Society,

J. B. Thomes, Pittsfield; C. S. Adams, Wollaston

Delegates to Rhode Island Medical Society,

J. H. Gifford, Fall River; E. W. Burt, Westport

To Connecticut State Medical Society,

F. B. Sweet, Springfield; Philip Kilroy, Springfield

To National Legislative Committee of the American Medical Association, February 23, at Chicago:

C. F. Withington

To Conference on Medical Education, February 24, and to the Association of American Medical Colleges, February 25, at Chicago:

H. C. Ernst

The secretary read the petition of Dr. N. N. Morse for reinstatement, and the following committee was appointed to consider the petition:

G. W. Winchester
T. E. Guild
W. H. Parker

The reports of the committees appointed to consider the petitions for reinstatement of the following six fellows were acted on by the council separately:

F. P. Hudnut	G. C. Moore
C. W. Rosenbloom	G. F. Keenan
A. E. Bertrand	D. G. Hoyt

It was voted to reinstate all of them except D. G. Hoyt of Providence, R. I. The committee in this case recommended that he be not reinstated and submitted a brief setting forth its reasons.

The secretary read two letters from the American Medical Association inviting him to attend a meeting of the secretaries of the state medical societies at the building of the American Medical Association in Chicago on February 25, and to present to this meeting the plan of organization of the Massachusetts Medical Society.

Dr. Arnold moved, and it was

Voted, That the council authorize the secretary of the Massachusetts Medical Society, or some member to be chosen by the president, to attend the proposed meeting of secretaries of the state societies and the conferences to be held at Chicago, February 23 to 25, and that the society defray expenses other than those paid by the American Medical Association.

A letter was read from Wisner R. Townsend, Secretary of the Medical Society of the State of New York, advocating the payment of the expenses of the delegates to the House of Delegates of the American Medical Association by the trustees of the American Medical Association. This was discussed by Dr. Arnold,

who said: "Having served as delegate to the American Medical Association for several years, and knowing that matters of this sort are considered by the trustees in a very fair spirit, and that they are ready to do everything that is for the good of the association and of the state societies that comes within their means, and inasmuch as this has been presented to the trustees, and it is a question of ways and means, about which we know very little, it seems to me that we are hardly in position to take action at the present time. If the trustees should vote in favor of such action and the association pays the expenses, we should be very glad to be relieved of that expense. If the trustees should decide at their meeting that it is inadvisable, I understand that the New York State Society is to bring the proposition before the House of Delegates, and I move that this matter be referred to our delegates at the next meeting of the House of Delegates of the American Medical Association for their consideration at that time."

It was so voted.

The treasurer read his report for the eight and one-half months ending December 31, 1913, and the report of the Auditing Committee was read by Dr. J. L. Huntington as follows:

The undersigned, a duly appointed committee, having examined the books of the treasurer of the Massachusetts Medical Society, find them correctly cast and properly vouched, and also that he has in his possession the securities called for.

DAVID N. BLAKELY
JAMES LINCOLN HUNTINGTON

January 29, 1914

Voted, To accept the reports.

Dr. Goss submitted the following report:

The Committee on Membership and Finance reports and recommends to the Council that the following be allowed to change their district membership without a change of legal residence:

Forrest L. Leland from Hampshire to Hampden
Harold Bowditch from Norfolk to Suffolk

Also that the following be placed on the retired list:

James P. Broidrick, Jamaica Plain
Walter Ela, Cambridge
Omar A. Flint, Dracut Center
Seth V. Goldthwaite, Boston
Leonard Huntress, Lowell
Samuel W. Langmaid, Brookline

Also that the resignations of the following be accepted:

Jane R. Baker, West Chester, Pa.
 Walter I. Baldwin, San Francisco, Cal.
 John M. Connolly, Portland, Oregon
 John W. Fairing, Greensburg, Pa.
 Wilho A. Groenlund, Seattle, Wash.
 Frank A. Hamilton, Boston
 Samuel H. Kagan, Augusta, Me.
 Milton H. Leonard, New Bedford
 Charles G. McGaffin, New York, N. Y.
 Jacob M. Morin, Brooklyn, N. Y.
 Samuel T. Orton, Worcester
 C. Augusta Pope, Boston
 Herbert A. Rice, Gay's Mills, Wis.
 Frederick S. Ward, Springfield

That appropriations for Standing Committees for the current financial year be recommended as follows:

Of Arrangements	\$3000
On Publications and Scientific Papers	3000
On Ethics and Discipline	100
On State and National Legislation	300
On Public Health	25

That three thousand dollars (\$3000) from the treasury be distributed among the district societies.

It was voted to accept the report and adopt its recommendations regarding membership. The appropriations for the standing committees were voted separately, as recommended, and it was voted that \$3000 from the balance in the treasury December 31, 1913, should be distributed as a dividend among the district societies. On a query by a councilor as to how the dividend is distributed, Dr. Buckingham said that by a vote passed some twenty or thirty or forty years ago, the dividend is distributed among the different district societies in proportion to the amount of the dues collected by the district treasurer previous to a definite date, the object being to spur district treasurers to get in payments promptly. The time when payments should be considered in advance or in arrears was in the past at the close of the annual meeting. Last year when the new by-laws were made, a provision was inserted that this time should be brought forward, so that now it is the 1st of June. Thus, in order that a district may be entitled to draw anything on this rebate, payment of dues must be made before June 1.

The dividend is not distributed according to the number of members in a district society, but according to the amount of dues paid up. The society which sends in twenty-five dues with

seventy-five members gets just one-third as much as the society which sends in the whole seventy-five dues before the stated time.

Dr. G. B. Shattuck presented the report of the Committee on Publications and Scientific Papers. He read the propositions submitted by Dr. Homer Gage at the meeting of the council October 1, 1913, and the vote referring the matter to the Committee on Publications, requiring a report at the next meeting of the council. (See page 13.)

The report of the committee was as follows:

The Committee on Publications and Scientific Papers have considered the proposition that the Massachusetts Medical Society should take over the Boston Medical and Surgical Journal, and do not consider this step would be wise even if the owners should consider favorably such a scheme.

The committee have considered the proposition that the Massachusetts Medical Society should issue a monthly bulletin of its own, and believe that the association with the Boston Medical and Surgical Journal outlined below offers greater advantages both to the society and to the Journal, and they therefore do not favor the independent issuance by the society of a monthly bulletin.

The committee have considered the proposition concerning the change in the method of issuing the various publications of the society and a possible closer association with the Boston Medical and Surgical Journal, and after conferences with the owners of the Journal, offer the following suggestions, which have already been favorably considered by the owners.

1st. That some connection between the Massachusetts Medical Society and the Boston Medical and Surgical Journal is advisable and feasible.

2nd. That the Boston Medical and Surgical Journal be incorporated under the laws of Massachusetts.

3rd. That after incorporation, the owners agree to give one share of stock to each member of a committee of three, to be appointed by the Massachusetts Medical Society, one of whom shall be the secretary of the society, which committee shall serve with the owners as directors of the Boston Medical and Surgical Journal, having control over its affairs.

4th. That when a representative of the Massachusetts Medical Society shall cease to serve on this committee he shall surrender his share of stock to the owners.

5th. That the owners agree that as long as the association with the Massachusetts Medical Society shall continue they will transfer their stock only to physicians approved by the board of directors.

6th. That there shall be added to the editorial staff of the Journal, to be appointed by the directors and with the approval

of the Editor-in-Chief, an editor or editors, who shall represent the Massachusetts Medical Society, and be members of the regular editorial staff on the Journal, having a voice in the conduct of the Journal as well as in matters which peculiarly concern the society.

7th. That in consideration of the advantages expected to be realized by the Massachusetts Medical Society from its association with the Boston Medical and Surgical Journal, and in further consideration of the fact that in the opinion of the present publisher such association may at least temporarily entail increased expense to the Journal, to meet which there are at present no available resources, the Massachusetts Medical Society agrees, if it is necessary in the opinion of the directors, to furnish to the directors from its funds a sum not to exceed two thousand dollars a year for three years to compensate the Journal for possible financial loss arising from its association with the Massachusetts Medical Society.

8th. That if the association between the Massachusetts Medical Society and the Boston Medical and Surgical Journal be terminated before three years have elapsed, the Massachusetts Medical Society shall not be held financially responsible for any losses to the Journal after the end of the calendar year in which the association is terminated.

The Committee on Publications and Scientific Papers further recommend:

1st. That if the above suggestions are adopted, the society abandon the separate publication of its proceedings and medical communications, and that as far as practicable it publish these and all other matter only in the Boston Medical and Surgical Journal, in such form as may be later determined. These publications shall be sent to each member of the society.

2nd. That as soon as possible some arrangement be made whereby each number of the Boston Medical and Surgical Journal be furnished to each member of the society.

3rd. That a special committee of three, one of whom shall be the secretary of the Massachusetts Medical Society, as previously stated, be appointed, with power to carry out the recommendations of the council and to serve with the owners as directors of the Boston Medical and Surgical Journal for one year.

After some discussion participated in by Drs. H. Gage, Worcester, Cotton, J. B. Blake, Crowell, J. W. Bartol, and Arnold, it was voted to accept the report.

On motion by Dr. J. B. Blake, the privileges of the floor were given to the members of the Committee on Publications and Scientific Papers, and Drs. Taylor and Osgood explained the provisions of the report. They favored a committee of three to consider and put into effect the recommendations of the committee.

Dr. Gage favored a committee to which to refer the report for further consideration on account of the importance of the matter. Dr. Crowell suggested that the question be referred to the Committee on Membership and Finance. Dr. Gage said it was immaterial to him whether it was given to a small committee, the Committee on Membership and Finance, or to an even larger committee, but on general principles, he believed that a smaller committee would be more efficient. Dr. Cotton thought the committee should be a larger one and representative of the state at large, and he moved that the committee consist of the following four officers of the society: president, vice-president, secretary, and treasurer, and five members of the council to be nominated from the floor. Dr. Harrington thought it would be better to have the five appointed by the chair, and proposed this as an amendment to Dr. Cotton's motion. The amendment being accepted by Dr. Cotton, the motion as amended was put by the president and was carried unanimously.

On motions by Drs. Palmer and Cook, it was voted to have the report of the Committee on Publications and Scientific Papers printed and sent to the members of the council, together with a report of the proposed committee of nine previous to the next meeting of the Council.

Dr. Ryder read the following report of the committee appointed to consider the working of the malpractice act:

Your committee appointed to consider what if any changes should be made in the "Act for the Defence of Suits for Malpractice" report that they recommend that the articles stand for the present as they are, with such explanations as are herein described.

Interpretations of the articles as given by the committee seemed to clear the atmosphere of misunderstanding and to give the secretary of the society a more succinct translation of them.

Our conclusions were based largely on a report which Dr. George W. Gay received from the secretaries of the various state societies which have a Medical Defence Act, in response to a number of questions which he propounded. The epitomized summary of those replies is as follows:

The following state medical societies, twenty in all, have a medical defence act for the protection of their members when sued for malpractice: New York, New Jersey, Pennsylvania, Illinois, Iowa, Michigan, Massachusetts, Minnesota, California, Kentucky, Kansas, Indiana, Maryland, West Virginia, North Dakota, Nebraska, Mississippi, Missouri, Vermont, and Wisconsin. In replies to inquiries from all except the last, the following facts show a remarkable unanimity of opinion and practice in the framing of the acts and in the enforcement of the same.

The act has been in force in the various states from two to twelve years, New York being first in the field, and having had a

a very large and a very successful experience in its use. The act is satisfactory in all the states with possibly one exception, the only state in which any move has been made to repeal the law.

The average number of suits brought annually in the different states varies from none to about twenty-five or thirty. Of course a much larger number of threatened actions call for consideration by the medical defence committees and are disposed of in various ways without coming to trial. In fact, this is one of the chief values of the act.

The approximate annual expense of the act in the different states varies from nothing to six thousand dollars. Only one spends more than thirty-five hundred dollars annually. During the five years that the Massachusetts Medical Society has had the act in force the annual expense has averaged \$385, or about eleven cents annually for each member.

None of the state societies pay verdicts. They pay for counsel and court fees and perhaps a few other contingent expenses.

Most of the societies do not pay the medical experts anything except traveling expenses, etc. Only four pay any expert fees and those are only nominal.

Most of the societies defend their members in all civil suits regardless of the merits of the case. The decision of this question rests with the medical defence committee in all the societies. Two states have no separate committee, the work being done by the president and secretary.

Private insurance is not generally encouraged. A few advise protection in damages, but not in defence alone. The objections to insurance against verdicts lie in the supposition that it encourages suits for the purpose of obtaining hush money, or settlements without trials. This can be obviated by a restraining clause in the policy.

Many of the societies aid those carrying private insurance, some dividing the expense with the company. Others only advise, but do not incur any expense. Nearly all of the societies recommend their members to depend upon their counsel; in other words, to place their cases immediately in the hands of the societies for defence. It must be apparent to all that the earlier a case receives investigation the better for the defence.

The evidence in relation to the advantages of the Medical Defence Act is overwhelmingly in its favor. In only one state has any effort ever been made to repeal and that was not successful. The medical associations through appropriate committees can do this work much better than any agency. They understand the nature of the situations far better than any others can. They are not in the work for the money they can get, but only to protect the innocent from imposition and fraud. As a rule the societies do not settle cases, and under no circumstances do they pay damages. Hence there is no inducement for a threatened suit

with that in view. They may advise the defendant in certain cases to settle, but he pays the bills, not the society.

The suggestions for amendments to the act as read at a previous meeting of the councilors which had for their ultimate aim a better understanding of the several articles of the act were as follows:

1. "The consideration of excluding from the benefits of our Defence Act all fellows who have insurance with commercial companies."

The committee report that any fellow according to *Article first* of the Act may avail himself of the privileges of this Act but that it is not the intent of the Act to join hands with commercial insurance companies. It is urged that all fellows when possible place their defence in the society's keeping.

2. "A more exact definition of the sort of suits to be defended by the society: Should a member palpably negligent or culpable be defended — or only those fellows whose suits involve blackmail?"

Most of the state societies do defend their members in *all* civil suits regardless of the case, the actual decision resting with the Medical Defence Committee. Your committee recommend that in our society the decision of this question in any individual case be left to the judgment and discretion of the president and secretary as specified in *Article fourth*.

3. "Are any suits to be settled? If so, when is the society to assent to the settlement by the fellow? Should the society ever pay anything toward a settlement?"

It is recommended that the president and secretary be empowered to *advise* settlement whenever in their judgment such course seems discreet and wise, but that the society shall not assume any responsibility for payment of such settlement.

4. "Should medical experts called by an attorney in suits against our fellows receive any remuneration from the society?"

It is recommended that expenses only be paid by the society.

5. "Should a regular committee be appointed to consider the various questions arising with reference to malpractice suits; *i.e.*, A committee on medical defence?"

While most of the states do have such separate committees, it is recommended in our case that the president and secretary constitute such an advisory board as provided in *Article fourth* of the Act.

6. "Is further advertising of the Act advisable?"

Your committee say no! Ignorance of the existence of the Act is fast being abolished. Every member on joining the society is furnished with a copy of this Act.

7. "Should all members irrespective of their means be urged to avail themselves of the benefits of the Act or only those in straitened circumstances? Should fellows be encouraged to give up commercial insurance and rely on our Act?"

It is recommended that all members avail themselves of our defence whenever possible to the end that suits brought for the purpose of obtaining hush money may be deterred. Private insurance that pays damages engenders suits. Society defence discourages suits.

It is further recommended that the committee on medical education make some inquiry relating to the amount of instruction on ethics given in the various schools, whose diplomas we recognize, particularly with reference to malpractice suits and the fact that the majority of such suits have been brought as a direct result of the attitude of a fellow practitioner.

Voted, To accept the report and adopt its recommendations.

The committee appointed to draft resolutions on the death of Dr. R. H. Fitz, consisting of F. C. Shattuck, J. Collins Warren, George W. Gay, L. M. Palmer, and Alfred Worcester, reported through Dr. Gay, as follows:

Resolved, That in the death of Dr. Reginald Heber Fitz the Massachusetts Medical Society, the medical profession, and the community suffer a grievous loss. Born in 1843, taking his M.D. from Harvard in 1868, he then passed two years in Europe, grounding himself thoroughly in the pathology of that day under Rokitansky in Vienna and Virchow in Berlin. His quality was promptly recognized and he was appointed Instructor in Pathological Anatomy in the Harvard Medical School in 1870, succeeding Dr. J. B. S. Jackson as Full Professor in 1878. In 1892, he was transferred to the chair of Theory and Practice, resigning in 1908, when the age limit, then in force, retired him from the Visiting Staff of the Massachusetts General Hospital, to which he was appointed in 1887. He thus rounded out thirty-eight years as a teacher of medicine. Notable as were his services as a teacher of students and wise promoter of advance in teaching methods his greatest services were as a teacher of the profession. In 1886, he read before the Association of American Physicians his masterly paper on "Perforating Inflammation of the Vermiform Appendix," which forced almost instant conviction that the appendix is the most frequent source of the dreaded "inflammation of the bowels," and also clearly setting forth the salient diagnostic features and surgical treatment. He also proposed the term "appendicitis," which has been universally adopted. In 1889, came his Middleton Goldsmith Lecture on "Pancreatitis," again shedding a flood of light upon ill-understood conditions. The paper on pancreatitis showed in an equally high degree with that

on the appendix the application to clinical medicine and surgery of accurate pathological knowledge, painstaking collection and sifting of the literature of the subject, and logical reasoning therefrom.

It is safe to say that no physician in recent times did more than Fitz to transfer treatment from the physician to the surgeon. And yet he was always conservative as regards operation and saw clearly the dangers inherent in the *furor secundi* sired by the safety of clean surgery. In his Anniversary Discourse before the New York Academy of Medicine in 1901 on "Some Surgical Tendencies from a Medical Point of View," and again in his Presidential Address to the Congress of American Physicians and Surgeons in 1907, entitled "The Border Land of Medicine and Surgery," he applied the curb to the excess of operative zeal. The character of his work and the rapid diffusion of knowledge secured merited recognition while he was still in his prime, and he was fortunate in enjoying for years the appreciation of his notable services to mankind.

Chief among the many honors which came to him were the Presidency of the Congress of American Physicians and Surgeons and the Honorary LL.D. from Harvard. He was always ready to serve the Massachusetts Medical Society in any capacity, and was Orator in 1894, choosing as his subject "The Legislative Control of Medical Practice," and treating it with his characteristic thoroughness and lucidity.

He was a firm and loyal friend with a warmth of heart best known to those who knew him best.

The society and the profession of medicine have lost a shining light; humanity has lost a friend. Let us take his example to heart, and strive each, according to his capacity and opportunity, to emulate though we cannot hope to rival it.

Voted, To accept the resolutions and send a copy to the family of Dr. Fitz.

The secretary read a communication from the New England Sub-Committee on Obstetrics of the American Association for the Study and Prevention of Infant Mortality, as follows:

The New England Sub-Committee on Obstetrics of the American Association for the Study and Prevention of Infant Mortality called a meeting on December 20, 1913, at the Boston Medical Library to talk over informally the midwife situation in Massachusetts and whether or not it was advisable to act in favor or against any possible legislation which may be introduced into the Legislature of 1914 in the State of Massachusetts. There were asked to this meeting representatives of the medical societies, philanthropic societies interested in the care of pregnant women, social workers, certain physicians, especially from the mill cities in the eastern part of the state. There were about thirty people

present at the meeting, Dr. H. W. M. Bennett of Manchester, New Hampshire, told of the workings of the Manchester City Mission where a group of public spirited physicians with the help of certain philanthropic individuals in the city have done practically all the obstetrics among the poor in the city of Manchester, which is largely a mill town. Dr. Arthur B. Emmons spoke of the work of the Maverick Dispensary at East Boston, where there were no students but the work is carried on by two physicians who give their services for five dollars for each case. Many questions were asked of the workings of the City Mission in Manchester and the Maverick Dispensary in East Boston and it was made clear that it was not necessary to have students in the community in order that the poor of the community may obtain good obstetric service. After a free discussion, Dr. Emmons brought before the meeting a set of resolutions which after discussion and some changes were adopted as follows:

Whereas, one hundred and fifty or more women are illegally practicing as midwives, and

Whereas, a proportion of the immigrant population are utilizing these midwives to obtain obstetric service as shown by various investigations, and

Whereas, this problem has been met successfully in at least one industrial city of New England having a large immigrant population, and

Whereas, private organizations in Boston are meeting the necessity among a portion of its immigrant population, and

Whereas the required standard of obstetrical proficiency for admission to practice of medicine in the State of Massachusetts is admittedly low, and

Whereas, a movement is on foot aimed to put the midwife in the immediate future on an equal standing with the physician before the law, Therefore

Be it resolved that this meeting, held under the auspices of the New England Sub-Committee on Obstetrics of the American Association for the Study and Prevention of Infant Mortality, urge the Massachusetts medical societies, through their geographic units, to organize immediately to meet the above situation in their respective districts by providing obstetric service especially to the large immigrant class, and

Be it resolved that the State of Massachusetts through the Board of Registration in Medicine be urged to amend its laws so as to bring them into conformity with modern medicine.

Be it further resolved that a copy of these resolutions be sent to the Board of Registration and the Massachusetts medical societies.

This was discussed by Dr. Cook, and it was

Voted, To accept the report.

The president nominated Dr. J. W. Stimson as supervising censor for the Worcester North District Society, to fill a vacancy, and he was appointed.

The resignation of Dr. F. W. Goss as a member of the Committee on Membership and Finance was read by the secretary. Dr. Gay said that his communication separates an old officer from the committee, and moved that in commemoration of his long and faithful service a rising vote of thanks be extended to Dr. Goss for his service.

The motion being put, all rose.

The president nominated Dr. Alfred Worcester to fill the vacancy made by Dr. Goss' resignation, and he was appointed.

Adjourned at 1.45 P.M.

WALTER L. BURRAGE,
Secretary.

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Massachusetts Medical Society.

TREASURER'S REPORT.

FEBRUARY, 1914.

MR. PRESIDENT AND FELLOWS:

Your Treasurer has to report as follows for the period, April 15, 1913, to January 1, 1914:

RECEIPTS.

Balance from last year		\$14,457.43
Assessments paid to Treasurer	\$753.00	
Assessments paid at Annual Meeting	469.00	
Assessments paid to District Treasurers:		
Barnstable	\$128.00	
Berkshire	303.00	
Bristol North	238.00	
Bristol South	515.00	
Essex North	629.00	
Essex South	751.00	
Franklin	170.00	
Hampden	748.00	
Hampshire	230.00	
Middlesex East	261.00	
Middlesex North	370.00	
Middlesex South	1,402.00	
Norfolk	1,760.00	
Norfolk South	198.00	
Plymouth	371.00	
Suffolk	2,529.00	
Worcester	955.00	
Worcester North	283.00	
	<u>\$11,841.00</u>	<u>11,841.00</u>
Total assessments	\$13,063.00	\$13,063.00
Premium on foreign check . . . . .		.06
Sale of dinner tickets		24.00
Income from investments:		
Massachusetts Bonds	\$297.50	

Savings Banks, general fund	21.48	
Savings Banks, Cotting fund	77.85	
	<u>\$396.83</u>	396.83
Interest on deposits subject to check:		
New England Trust Co.	\$173.08	
Bay State Trust Co.	147.55	
	<u>\$320.63</u>	320.63
		<u>\$28,261.95</u> \$28,261.95

EXPENSES.

President's expense:		
Stamped envelopes		\$6.00
Secretary's expense:		
Stamps, filing case, typewriter ribbon	\$16.70	
History of Harvard Medical School	12.00	
Mailing tubes	4.00	
Envelopes, postal cards, stamps	82.66	
Printing	34.40	
Engraving certificates	15.00	
Stenographers at Annual Meeting	55.00	
Incidentals	17.41	
	<u>\$237.17</u>	237.17
Librarian's expense:		
Printing	7.75	
Stationery	2.75	
Postage and expressing	175.67	
Repairs to typewriter	20.00	
	<u>\$206.17</u>	\$206.17
Treasurer's expense:		
Printing and stamped envelopes	\$111.32	
Account book, letter file, index cards	\$6.10	
Clerical service	51.60	
Clerks at Annual Meeting	65.00	

Box at Bay State Trust		
Co.	10.00	
Treasurer's bond	37.50	
	<u>\$281.52</u>	\$281.52
District Treasurers' expense:		
Commissions	\$591.55	
Printing and postage . . .	187.47	
	<u>\$779.02</u>	\$779.02
Bank charges		1.50
Supervisors' expense		28.30
Censors' expense		447.00
Shattuck lecture:		
Harvey Cushing	\$200.00	
Am. Engraving Co., charts	42.75	
	<u>\$242.75</u>	242.75
Cotting lunch:		
June	\$138.75	
October	58.60	
	<u>\$197.35</u>	\$197.35
Payments to Medical Library		375.00
Salaries to January 1		1,231.78
Rebates to Districts		4,000.00
Defence of malpractice suits		470.00
Expenses on account of Am. Medical Assoc.		404.51
Committee on Publications and Scien- tific Papers:		
Printing and mailing	\$2688.91	
Expressage	6.72	
	<u>\$2,695.63</u>	\$2,695.63
Committee on By-laws:		
Printing and proof- reading	\$106.80	
Stenographer	20.00	
Addressing drafts	7.50	
	<u>\$134.30</u>	134.30
Committee on State and National Legislation:		
Stenographer and type- writing		4.00

Committee on Membership and Finance:

Printing	\$2.35	
Postage	2.03	
	<u>\$4.38</u>	4.38

Committee of Arrangements:

Printing	\$137.90	
Stamps and envelopes .	43.50	
Addressing circulars and programs	22.50	
Lanterns and operator .	50.00	
Signboards	4.70	
Blackboards	4.40	
Badges	1.17	
Hotel Copley Plaza . .	4,021.95	
Music	125.00	
Cigars	93.00	
	<u>\$4,504.12</u>	\$4,504.12

Committee on Public Health:

Traveling expenses		14.44
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Committee on Relations with American

Medical Association and with other
State Societies:

Traveling expenses		2.27
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Return of over payments		4.00
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	<u>\$16,271.21</u>	\$16,271.21
Balance January 1, 1914		11,990.74
		<u>\$28,261.95</u>

This balance is distributed as follows:

Deposit in New England Trust Co.	\$4,424.97
Deposit in Bay State Trust Co.	7,569.96
Not deposited	11.00

	<u>\$12,005.93</u>
Deduct check No. 2546, still out	15.19
	<u>\$11,990.74</u>

The above mentioned \$11 have since been deposited in the
New England Trust Co.

The investments of the society are unchanged. They are as follows:

Shattuck Fund:

Annuity Policy Mass. Hospital Life Ins. Co. . . \$9,166.87

Phillips Fund:

Massachusetts 3½ per cent gold bonds 10,000.00

Cotting Fund:

Deposit Roxbury Institution for Savings . . . 1,000.00

Deposit Provident Institution for Savings . . . 1,000.00

Deposit Suffolk Savings Bank 1,000.00

Permanent Fund:

Annuity Policy Mass. Hospital Life Ins. Co. . . 11,253.30

Massachusetts 3½ per cent gold bonds 6,000.00

Deposit Franklin Savings Bank 1,074.48

\$40,494.65

January 29, 1914.

EDWARD M. BUCKINGHAM,
Treasurer.